

00195



Alcoholism with delirium tremens.

Alcoholism with delirium tremens.

11-11-11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00199

CERTIFICATE OF DEATH

Reg. Dist. No.

00196

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home		d. STREET ADDRESS 3234 Clifton Ave.,	
3. NAME OF DECEASED (Type or print) James H. Alder		4. DATE OF DEATH Month Jan. Day 29 Year 1962.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Alder		14. MOTHER'S MAIDEN NAME Anne Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-05-0899	
17. INFORMANT Newton M. Alder		Address 5101 Brookgreen Rd. (29)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertensive Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 1 week 10 3/4	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 25, 1962 , to Jan. 29, 1962 , that I last saw the deceased alive on Jan. 29, 1962 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		ADDRESS (Street, city or town, state) DATE SIGNED 1-30-62	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		Baltimore - 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-1962	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Howard Strong		ADDRESS 3207 N. North Ave.	
24a. REC'D BY REGISTRAR DATE JAN 31 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1911

Reg. No. 1111

<p>1. Name of deceased: <u>ALICE</u></p>		<p>2. Sex: <u>F</u></p>	
<p>3. Age: <u>30</u></p>		<p>4. Date of birth: <u>1881</u></p>	
<p>5. Place of birth: <u>ALBANY, N.Y.</u></p>		<p>6. Date of death: <u>1911</u></p>	
<p>7. Cause of death: <u>Consumption</u></p>		<p>8. Date of burial: <u>1911</u></p>	
<p>9. Name of physician: <u>Dr. J. H. Smith</u></p>		<p>10. Name of undertaker: <u>John Doe</u></p>	
<p>11. Name of funeral home: <u>John Doe</u></p>		<p>12. Name of cemetery: <u>Greenwood</u></p>	
<p>13. Name of burial place: <u>Greenwood</u></p>		<p>14. Name of burial place: <u>Greenwood</u></p>	
<p>15. Name of burial place: <u>Greenwood</u></p>		<p>16. Name of burial place: <u>Greenwood</u></p>	
<p>17. Name of burial place: <u>Greenwood</u></p>		<p>18. Name of burial place: <u>Greenwood</u></p>	
<p>19. Name of burial place: <u>Greenwood</u></p>		<p>20. Name of burial place: <u>Greenwood</u></p>	
<p>21. Name of burial place: <u>Greenwood</u></p>		<p>22. Name of burial place: <u>Greenwood</u></p>	
<p>23. Name of burial place: <u>Greenwood</u></p>		<p>24. Name of burial place: <u>Greenwood</u></p>	
<p>25. Name of burial place: <u>Greenwood</u></p>		<p>26. Name of burial place: <u>Greenwood</u></p>	
<p>27. Name of burial place: <u>Greenwood</u></p>		<p>28. Name of burial place: <u>Greenwood</u></p>	
<p>29. Name of burial place: <u>Greenwood</u></p>		<p>30. Name of burial place: <u>Greenwood</u></p>	
<p>31. Name of burial place: <u>Greenwood</u></p>		<p>32. Name of burial place: <u>Greenwood</u></p>	
<p>33. Name of burial place: <u>Greenwood</u></p>		<p>34. Name of burial place: <u>Greenwood</u></p>	
<p>35. Name of burial place: <u>Greenwood</u></p>		<p>36. Name of burial place: <u>Greenwood</u></p>	
<p>37. Name of burial place: <u>Greenwood</u></p>		<p>38. Name of burial place: <u>Greenwood</u></p>	
<p>39. Name of burial place: <u>Greenwood</u></p>		<p>40. Name of burial place: <u>Greenwood</u></p>	
<p>41. Name of burial place: <u>Greenwood</u></p>		<p>42. Name of burial place: <u>Greenwood</u></p>	
<p>43. Name of burial place: <u>Greenwood</u></p>		<p>44. Name of burial place: <u>Greenwood</u></p>	
<p>45. Name of burial place: <u>Greenwood</u></p>		<p>46. Name of burial place: <u>Greenwood</u></p>	
<p>47. Name of burial place: <u>Greenwood</u></p>		<p>48. Name of burial place: <u>Greenwood</u></p>	
<p>49. Name of burial place: <u>Greenwood</u></p>		<p>50. Name of burial place: <u>Greenwood</u></p>	
<p>51. Name of burial place: <u>Greenwood</u></p>		<p>52. Name of burial place: <u>Greenwood</u></p>	
<p>53. Name of burial place: <u>Greenwood</u></p>		<p>54. Name of burial place: <u>Greenwood</u></p>	
<p>55. Name of burial place: <u>Greenwood</u></p>		<p>56. Name of burial place: <u>Greenwood</u></p>	
<p>57. Name of burial place: <u>Greenwood</u></p>		<p>58. Name of burial place: <u>Greenwood</u></p>	
<p>59. Name of burial place: <u>Greenwood</u></p>		<p>60. Name of burial place: <u>Greenwood</u></p>	
<p>61. Name of burial place: <u>Greenwood</u></p>		<p>62. Name of burial place: <u>Greenwood</u></p>	
<p>63. Name of burial place: <u>Greenwood</u></p>		<p>64. Name of burial place: <u>Greenwood</u></p>	
<p>65. Name of burial place: <u>Greenwood</u></p>		<p>66. Name of burial place: <u>Greenwood</u></p>	
<p>67. Name of burial place: <u>Greenwood</u></p>		<p>68. Name of burial place: <u>Greenwood</u></p>	
<p>69. Name of burial place: <u>Greenwood</u></p>		<p>70. Name of burial place: <u>Greenwood</u></p>	
<p>71. Name of burial place: <u>Greenwood</u></p>		<p>72. Name of burial place: <u>Greenwood</u></p>	
<p>73. Name of burial place: <u>Greenwood</u></p>		<p>74. Name of burial place: <u>Greenwood</u></p>	
<p>75. Name of burial place: <u>Greenwood</u></p>		<p>76. Name of burial place: <u>Greenwood</u></p>	
<p>77. Name of burial place: <u>Greenwood</u></p>		<p>78. Name of burial place: <u>Greenwood</u></p>	
<p>79. Name of burial place: <u>Greenwood</u></p>		<p>80. Name of burial place: <u>Greenwood</u></p>	
<p>81. Name of burial place: <u>Greenwood</u></p>		<p>82. Name of burial place: <u>Greenwood</u></p>	
<p>83. Name of burial place: <u>Greenwood</u></p>		<p>84. Name of burial place: <u>Greenwood</u></p>	
<p>85. Name of burial place: <u>Greenwood</u></p>		<p>86. Name of burial place: <u>Greenwood</u></p>	
<p>87. Name of burial place: <u>Greenwood</u></p>		<p>88. Name of burial place: <u>Greenwood</u></p>	
<p>89. Name of burial place: <u>Greenwood</u></p>		<p>90. Name of burial place: <u>Greenwood</u></p>	
<p>91. Name of burial place: <u>Greenwood</u></p>		<p>92. Name of burial place: <u>Greenwood</u></p>	
<p>93. Name of burial place: <u>Greenwood</u></p>		<p>94. Name of burial place: <u>Greenwood</u></p>	
<p>95. Name of burial place: <u>Greenwood</u></p>		<p>96. Name of burial place: <u>Greenwood</u></p>	
<p>97. Name of burial place: <u>Greenwood</u></p>		<p>98. Name of burial place: <u>Greenwood</u></p>	
<p>99. Name of burial place: <u>Greenwood</u></p>		<p>100. Name of burial place: <u>Greenwood</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
1
M
50
I
0
1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00200
00197
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE New Jersey b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmyra 67X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 307 West Third Street	
3. NAME OF DECEASED (Type or print) First THOMAS Middle BERNARD Last ALLEN		4. DATE OF DEATH Month January Day 19 Year 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1915
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Riverton, New Jersey	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Allen		14. MOTHER'S MAIDEN NAME Phoebe Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 149-01-5156	
17. INFORMANT Clin Rec VAH Baltimore Md - Ft Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX DUE TO Conditions, if any, which gave rise to immediate cause (b) 161X (a), stating the underlying cause last. (c) 161X DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) TUBERCULOSIS, PULMONARY MODEPATELY ADVANCED 002.1 INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 31 19 61 to Jan. 19 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 19 19 62 , and that death occurred at 9:10 p.m., from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert M.D.		22b. DATE SIGNED 1-20-62	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, Balto. 18 Md., Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Berkley National Cemetery		23d. LOCATION (City, town or county) (State) Berkley, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. Talbert for Tunsil Funeral Home		25a. REC'D BY REGISTRAR DATE JAN 23 '62	
ADDRESS 410 Market St. Palmyra, N.J.		25b. REGISTRAR'S SIGNATURE Arthur L. Talbert	

1920

M

new jersey

Belmont

Paterson

1920

Paterson

1920

Paterson

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

1920

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **00199**

00202

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7448 Edsworth Road				d. STREET ADDRESS 7448 Edsworth Road #22			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First UDA Middle G. Last ANDERSON				4. DATE OF DEATH Month Jan. Day 9 Year 1962					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/15/85		9. AGE (In years last birthday) yrs. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Delta Pa.			12. CITIZEN OF WHAT COUNTRY? 		
13. FATHER'S NAME William J. Bennington				14. MOTHER'S MAIDEN NAME Margaret Bullett					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Mildred Antis, dght. above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the urethra & bladder DUE TO with generalized metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia & Secondary Anemia DUE TO Generalized arteriosclerosis (c)								INTERVAL BETWEEN ONSET AND DEATH Aug 1961 Jan 3-1962	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-3 1962 to 1-9 1962 , that I last saw the deceased alive on 1-9 1962 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7448 Edsworth Road Dundalk 22 Md DATE SIGNED									
ACTUAL SIGNATURE Eugene F. New M.D.				PHYSICIAN'S NAME (Type) Eugene F. New M.D. Dundalk 22 Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1/13/62		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles E. Schimunek Funeral Home 3331 Brehms Lane						24a. REC'D BY REGISTRAR DATE JAN 15 '62		24b. REGISTRAR'S SIGNATURE O. B. P. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore		COUNTY Baltimore	
NAME OF DECEASED William A. Brown		SEX Male	
DATE OF DEATH 1918		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH Baltimore		AGE 45	
OCCUPATION Clerk		CAUSE OF DEATH Pneumonia	
MEDICAL HISTORY None		PREVIOUS ILLNESS None	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

This certificate is to be filled out by the physician or coroner in charge of the case. It should be filled out as soon as the death has occurred, and should be filed in the office of the Registrar of the Department of Health. The certificate should be filled out in duplicate, and the original should be filed in the office of the Registrar, and the duplicate should be filed in the office of the physician or coroner.

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
00201																	
00198																	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b <u>7 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3001-4</u> d. STREET ADDRESS <u>3113 Woodland Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>CORNELIUS</u> Middle <u>J.</u> Last <u>ANGLAND</u>						4. DATE OF DEATH Month <u>JANUARY</u> Day <u>26</u> Year <u>19 62</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 21, 1889</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13. FATHER'S NAME <u>Morris Angland</u>						14. MOTHER'S MAIDEN NAME <u>Ellen Callahan</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service) <u>WW I</u>						16. SOCIAL SECURITY NO. <u>216-01-5392</u>						17. INFORMANT <u>Clinical Records, VA Hospital, 3900 Loch Raven Blvd. Ft. Howard Division</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>491 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PARKINSONISM</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease, Chronic Brain Syndrome, secondary to / Cerebral Arteriosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>January 19, 1962</u> to <u>January 26, 1962</u> that <u>he</u> (we) last saw the deceased alive on <u>January 26, 1962</u> , and that death occurred <u>6:40 PM</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Antonio Bulls</u> 22c. PHYSICIAN'S NAME (Type) <u>ANTONIO BULLS, M.D.</u>						22b. DATE SIGNED <u>1/27/62</u> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>											
22d. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIVISION</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/30/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon Lemmon</u> C. Vernon Lemmon Funeral Home, 4611 Park Hts. Ave. Balto 15, Md.						25a. REC'D BY REGISTRAR DATE <u>JAN 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>									

... and also ...

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00203 CERTIFICATE OF DEATH 00200											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balt					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 46yr7mth23dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS Bayview Hospital	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Frank Middle Arnold Last Arnold						4. DATE OF DEATH Month January Day 15 Year 1962					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tobacco blender				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Joseph Arnold						14. MOTHER'S MAIDEN NAME Carrie Hilgefort					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident											
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. 19 p.m.		Month, Day, Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 22 1915 to Jan. 15 1962 that (I) (we) last saw the deceased alive on Jan. 15 1962 , and that death occurred at 7:40 M, from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachsler M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1-15-62		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-1962		23c. NAME OF CEMETERY OR CREMATORY Wesley Meth				23d. LOCATION (City, town or county) (State) Annall Co Md			
24. FUNERAL DIRECTOR'S SIGNATURE Thpton-Elmer W. Accompted Md						ADDRESS		25a. REC'D BY REGISTRAR 16 '62		25b. REGISTRAR'S SIGNATURE Charles S. Hanna	

PERSON

STATE OF TEXAS

6853

(M)

X

I

James G. ...

for ...

Public ...

1-1-1902 ...
...
...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 102011

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Essey</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>102 N. Stuart St. Balto. 21</u>				d. STREET ADDRESS <u>102 N. Stuart St. (21)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>MAY</u> Last <u>Bader</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>24</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>March 18, 1887</u>		8. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Shaw</u>				14. MOTHER'S MAIDEN NAME <u>Agnes De Jay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Husband (Same as above)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA of Ovary</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>16 Months</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland's Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly 418 Eastern Blvd.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 29 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Catharine E. Hanna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G305 1/18/62 mh

00205

CERTIFICATE OF DEATH

Reg. Dist. No.

00202

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 1/2 Winters Lane		d. STREET ADDRESS 60 1/2 Winters Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle F. Last BANKS		4. DATE OF DEATH Month Jan. Day 10 Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1891
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Ross		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Gertrude Smith 60 1/2 Winters Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency 2 yrs. 1 Mo. 16 Days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Renal Disease ? DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from II-25-59 , 19____, to I-10-62 , 19____, that I last saw the deceased alive on I-10-62 , 19____, and that death occurred at 8.30AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C.F. Maloney, M.D. M.D. 57 Winters Lane I-10-62 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) C.F. Maloney, M.D. Catonsville 28. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-62	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE M. Francis E. Hensley		24a. REC'D BY REGISTRAR DATE JAN 16 '62	
ADDRESS 578 W. Biddle St.		24b. REGISTRAR'S SIGNATURE Arthur E. Hensley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
00206

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00203

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 3 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle HERBERT Last BARNES				4. DATE OF DEATH Month JANUARY Day 4 Year 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 11, 1893	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 6 Days 18 Hours 15 Min.		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown - retired				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) TROY, NEW YORK	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME FRANK BARNES, SR				14. MOTHER'S MAIDEN NAME HARRIET HOLBROOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 093-05-7466		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PULMONARY TUBERCULOSIS INTERVAL BETWEEN ONSET AND DEATH one year 2 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE 002.1.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/5 19 61 to 1-4 19 62 that (I) (we) last saw the deceased alive on JAN. 4 19 62 and that death occurred at 6:30 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				22b. DATE SIGNED JAN 14/62			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-4-62				23b. DATE THEREOF 1-4-62			
23c. NAME OF CEMETERY OR CREMATORY ELMWOOD				23d. LOCATION (City, town, or county) Troy, N.Y., N.Y.			
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newcomer				25a. REC'D BY REGISTRAR DATE JAN 8 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass							

10500

10500

10500

M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00207
00204

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard		MARYLAND c. LENGTH OF STAY IN 1b 294		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Box 288 RR 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD C. BAUER		4. DATE OF DEATH Month January Day 11 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1897	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Exp. Sta. Relay, Maryland		11. BIRTHPLACE (County & State, or foreign country) U. S. A.	
13. FATHER'S NAME Louis Bauer		17. MOTHER'S MAIDEN NAME Mary Phitzmeyer or Mary Fitzmaier			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-09-2315		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE INVOLVING LYMPH NODES, LIVER, KIDNEYS AND BONES Conditions, if any, which gave rise to immediate cause (b) PULMONARY CONGESTION AND EDEMA (c) DUE TO 201X XXXX PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UROLITHIASIS, WITH CHRONIC CYSTITIS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN RECENT	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 23 3:48 61 January 11, 62	
20f. (City or town) January 11, 62		20g. (County) 19		20h. (State) 19	
21. I certify that (X) (this hospital) attended the deceased from January 11 1962 to January 11, 1962 , that (X) (we) last saw the deceased alive on January 11 1962 , and that death occurred at A.M. from the causes and on the date stated above.					
22a. SIGNATURE Thomas F. Crahan, M.D.		22b. DATE SIGNED 1/11/62		22c. PHYSICIAN'S NAME (Type or print) THOMAS F. CRAHAN, M.D.	
22d. ADDRESS VAH, BALTIMORE 18 MD FT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkins Ave. Balto. Md.		25a. REC'D BY REGISTRAR JAN 16 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

Howard H. Hubbard, 4101 Williams Ave. Beltsville, Md.

Baltimore National Company, Baltimore, Md., Maryland

Mr. Hubbard, 4101 Williams Ave. Beltsville, Md.

THOMAS E. CLEARY, M.D.

[Handwritten signature]

January 11, 1952

March 23, 1952

January 11, 1952

PROLIFERATION, WITH CHRONIC CYSTITIS

PROLIFERATION, WITH CHRONIC CYSTITIS

PROLIFERATION, WITH CHRONIC CYSTITIS

PROLIFERATION, WITH CHRONIC CYSTITIS

PROLIFERATION, WITH CHRONIC CYSTITIS

64-60-5315

W 1

Yes

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Louis H. Hubbard

Printer

Wife

Male

June 2, 1952

BAUER

O.

REWARD

January 11, 1952

Maryland

Baltimore

Beltsville

Baltimore

Baltimore



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00208

CERTIFICATE OF DEATH

Reg. Dist. No.

00205

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X. Randallstown</u>	
c. LENGTH OF STAY IN 1b <u>4 mos.</u>		d. STREET ADDRESS <u>9121 Bengal Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9121 Bengal Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>William Henry</u> Last <u>Bender</u>		4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1962</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28, 1913</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>18</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Radio</u>	
11. BIRTHPLACE (State or foreign country) <u>Fort Wayne Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George I. Bender</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Honeich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or date of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>305-14-5958</u>	
17. INFORMANT <u>Mr. Allen Perkar</u>		Address <u>759 McKevlin Ave. Balto 18</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA.</u> DUE TO <u>4-20-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR.</u> <u>1 HR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>1</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 20, 1961</u> , to <u>JAN 18, 1962</u> , that I last saw the deceased alive on <u>JAN 18, 1962</u> , and that death occurred at <u>12:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ronald Berger</u>		ADDRESS (Street, city or town, state) <u>8501 LIBERTY RD.</u>	
PHYSICIAN'S NAME (Type) <u>RONALD BERGER, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Research</u>		22b. DATE THEREOF <u>1-18-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>School John Hopkins Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Spring Byers</u>		ADDRESS <u>8728 Liberty Road Randallstown, Md.</u>	
24a. REC'D BY REGISTRAR <u>JAN 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>James E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
M
X
I
0

349

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00203 CERTIFICATE OF DEATH 00206

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest c. LENGTH OF STAY IN 1b 45 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7440 Bay Front Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest d. STREET ADDRESS 7440 Bay Front Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CATHERINE AGNES BIRMINGHAM		4. DATE OF DEATH Month Day Year January 14th, 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1894
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Maley	
14. MOTHER'S MAIDEN NAME Delia Durkin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT M.J. Birmingham, Sr., same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from July 15th, 1960 to January 14, 1962 that (I) was last saw the deceased alive on January 14, 1962 and that death occurred at 7 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John V. Conway, 22c. PHYSICIAN'S NAME (Type) John V. Conway, M.D.		22b. DATE SIGNED 1/15/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/62	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemty.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		25a. REC'D BY REGISTRAR JAN 17 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

100806

100806

2 minutes

10 years

Antisocial behavior

infectious

10/2/06

John V. Gurney

TO HOSPITAL OR A NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00210					00207									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>Garrison</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Forsleigh Nursing</u> c. LENGTH OF STAY IN 1b <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>6 Upland Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Lulu</u> Middle <u>R.</u> Last <u>Bissell</u>					4. DATE OF DEATH Month <u>Jan</u> Day <u>10</u> Year <u>1962</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 24 1872</u>		9. AGE (In years last birthday) <u>89</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>						
13. FATHER'S NAME <u>Phillip Dingle Dine</u>					14. MOTHER'S MAIDEN NAME <u>Catherine Miller</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>-</u>					17. INFORMANT <u>MRS. EDWARD B. WRIGHT</u> Address <u>ABOVE</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Senile Arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)					
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 14</u> , 19 <u>61</u> , to <u>Jan 10</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>JAN 10</u> , 19 <u>62</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Sheppard K. Brown</u> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-10-62</u>							
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>			23b. DATE THEREOF <u>JAN. 13, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		23d. LOCATION (City, town or county) <u>BALTIMORE</u>		(State) <u>MO.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS & Sons Co.</u>					ADDRESS <u>4905 YORK RD. BALTO.</u>		25a. REC'D BY REGISTRAR <u>JAN 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>G. J. Smith & Sons</u>					



(1)

10301

CHICKEN CAKE OF BREAD

800013

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "CHICKEN CAKE" and "BREAD" are visible.]

HOW JENNINGS / 2000 Co 4102 York Rd
Glenview, Ill 60015
Jan 13, 1964
Patterson

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be examined by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14

1

1

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00211						00208					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Baltimore City MARYLAND						e. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						c. LENGTH OF STAY IN 1b March 17, 1958 X Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital						d. STREET ADDRESS Rosebank Road - Baltimore-22, Md.					
3. NAME OF DECEASED (Type or print) Mary						4. DATE OF DEATH January 20 1962					
5. SEX Female						6. COLOR OR RACE white					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 1881 80 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY AT HOME					
11. BIRTHPLACE (County & State, or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Henry SCHULTZ						14. MOTHER'S MAIDEN NAME Mary ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. no					
17. INFORMANT Mr. Steven BLACK (son) - Box 8203, Rosebank Rd.						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure						INTERVAL BETWEEN ONSET AND DEATH sudden					
4-22-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardio Vascular Disease with Aortic and Mitral Insufficiency. Myocardial Damage.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m. none						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none						20f. (City or town) (County) (State) none					
21. I certify that (I) (this hospital) attended the deceased from March 17, 1958 to January 20, 1962 that (I) (we) last saw the deceased alive on 19 and that death occurred at 19 M, from the causes and on the date stated above.											
22a. SIGNATURE Imre KOPITS						22b. DATE SIGNED January 20, 1962					
22c. PHYSICIAN'S NAME (Type) Imre KOPITS, M.D.						22d. ADDRESS Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE THEREOF 1/22/62					
23c. NAME OF CEMETERY OR CREMATORY SACRED HEART						23d. LOCATION (City, town or county) (State) BALTO. Co. MD.					
24. FUNERAL DIRECTOR'S SIGNATURE B.W. Hoffmann						25a. REC'D BY REGISTRAR JAN 23 '62					
25b. REGISTRAR'S SIGNATURE Arthur L. Finner											

115011

(BLACK)

1801 30

At Home

1/23/12 SACRED HEART
St. Mary's 315 Hudson St

BATON

M/D

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00212					00209				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Baltimore					b. COUNTY Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holbrook					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 5713 Stonington Avenue #7				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Alton G Blackburn					4. DATE OF DEATH January 6, 1962				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Oct. 17-1885				
9. AGE (In years last birthday) 76 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10b. KIND OF BUSINESS OR INDUSTRY Construction				
11. BIRTHPLACE (County & State, or foreign country) Virginia					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO.				
17. INFORMANT Mr. Stanley Blackburn-5713 Stonington Avenue					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20f. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ***** 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 10 years									
21. I certify that (I) Millard T. Traband, Jr. attended the deceased from....., 19....., to Jan. 5, 1962, that (I) was saw the deceased alive on Jan. 5, 1962, and that death occurred at 11 A.M. from the causes and on the date stated above.									
22a. SIGNATURE <i>Millard T. Traband, Jr.</i>					22b. DATE SIGNED 1/6/62				
22c. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr.					22d. ADDRESS 5101 Gwynn Oak Ave. Baltimore, 7, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-9-62				
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery					23d. LOCATION (City, town or county) (State) Woodlawn, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Pickens & Son, Baltimore, Md.</i>					25a. REC'D BY REGISTRAR JAN 8 '62				
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>									

00000



So

1917-18

Income

1917-18

Income of 1917-18

1917-18

Income of 1917-18

Income of 1917-18

1917-18

1917-18

1917-18

1917-18

1917-18

1917-18

00213

(M)

(1)

[Faint, illegible handwritten text, possibly a signature or address]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00214

00211

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b Towson d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1300 Red Fox Ct. Towson 4, Md.				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland Baltimore b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 d. STREET ADDRESS 1300 Red Fox Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Harry R BOYD		4. DATE OF DEATH Month January Day 6 Year 19 62		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 6, 1896		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive Jobber				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Boyd		14. MOTHER'S MAIDEN NAME Annie Bray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) WW I				16. SOCIAL SECURITY NO. 216-32-7186		17. INFORMANT Address Mrs. Louise E. Boyd, 1300 Red Fox Ct. Towson 4							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 4-20-62 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 1 YEAR			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from MAY 1957 to JAN 6, 1962 that (I) (we) last saw the deceased alive on Dec. 29, 1961 and that death occurred at 12:30 AM from the causes and on the date stated above.													
22a. SIGNATURE Adam G. Swiss						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) ADAM G. SWISS		22d. ADDRESS 6232 BELAIR ROAD, BALTO. 6, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1-9-62		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery				23d. LOCATION (City, town or county) Baltimore		(State)	
24 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, TOWSON						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

00821

00821



Belmont

Belmont

John

Town

1900 Red Fox Court

January 6, 1965

Case 6,186

Wife

Automotive Shop

Self employed

Henry Love

Female in 2

210-32-7186 Washington, D.C. 20501 Tel for U.S. Town

W 1

Washington, D.C. 20501

Post Office Box 1000

Post Office Box 1000

1-1-65

1-1-65

1-1-65

1-1-65 1-1-65 1-1-65 1-1-65 1-1-65 1-1-65 1-1-65 1-1-65 1-1-65 1-1-65

1

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00215^{DLV}

00212

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 28 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS Box 559		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ADAM (BRUKIEWA) BROOKS		4. DATE OF DEATH Month 1 Day 27 Year 1962							
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/3/1905		9. AGE (In years last birthday) yrs. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES — BRUKIEWA		14. MOTHER'S MAIDEN NAME MA — CIESLAK							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-8739		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Carcinoma of the lung with Metastases; and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO massive Hemorrhage of Pulm. T.B. (c) 002.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002.1		INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12-29-1961 to 1-27-1962 that (I) (we) last saw the deceased alive on 1-27-1962 and that death occurred at 11 A.M. from the causes and on the date stated above.		22a. SIGNATURE W. Newcomer		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/27/62			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan, 30-1962		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town, or county) (State) A. A. Co. Brooklyn, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE George A. Weher		ADDRESS 705 SOUTH ANN ST		25a. REC'D BY REGISTRAR DATE JAN 29 '62		25b. REGISTRAR'S SIGNATURE Arthur J. ...			

1945

CERTIFICATE OF MENTAL

60518

STATE OF NEW YORK

IN SENATE

January 10, 1945

REPORT

OF THE

COMMISSIONER OF MENTAL HYGIENE

TO THE SENATE

IN SENATE

January 10, 1945

REPORT

OF THE

COMMISSIONER OF MENTAL HYGIENE

TO THE SENATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
5. SEX				6. COLOR OR RACE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. AGE (In years last birthday)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work et work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Jan 19, 1959 to Jan 20, 1962, that (I) (we) last saw the deceased alive on Jan 20, 1962, and that death occurred at 12 P.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Arthur S. Thomas</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-23-62 23c. NAME OF CEMETERY OR CREMATORY Stone Chapel Cemetery 23d. LOCATION (City, town or county) Pikesville, Md. (State) 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Wm J. Jackson & Sons</u> Baltimore, Md. DATE JAN 23 '62 <u>Arthur S. Thomas</u>							

1941

1941



1941

1941

1941

1941

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				e. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN TB				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
1. PLACE OF DEATH				2. USUAL RESIDENCE			
a. COUNTY <i>Baltimore</i> MARYLAND				e. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN <i>Overlea</i>				c. CITY OR TOWN <i>Overlea</i>			
c. LENGTH OF STAY IN TB				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION <i>529 Old Home Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
First Middle Last				Month Day Year			
<i>Mr. Charles Henry Buckley</i>				<i>January 25th 19 62</i>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
<i>male</i>		<i>white</i>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>Jan. 27, 1867</i>	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<i>94</i> yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country)			
<i>Ret. Mechanical Engineer</i>				<i>Shappsburg, Maryland</i>			
12. CITIZEN OF WHAT COUNTRY?							
<i>U.S.A.</i>							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Rev. J. W. Buckley</i>				<i>Mary Rishel</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
				<i>220/05/8239</i>			
17. INFORMANT				Address			
<i>Mr. Rishel Buckley</i>				<i>529 Old Home Road.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				<i>Arteriosclerotic Heart Disease</i>			
420.0 DUE TO				<i>2 yrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) <i>Generalized Arteriosclerosis</i>			
DUE TO				<i>5 yrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour e.m. p.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>March 4, 1962</i> to <i>Jan 25, 1962</i> , that (I) (we) last saw the deceased alive on <i>Jan 24, 1962</i> , and that death occurred at <i>11 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
<i>George Sawyer</i> M.D.				<i>1/25/62</i>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
<i>GEORGE SAWYER - M.D.</i>				<i>4808 Harford Rd. Balto 14</i>			
23a. BURIAL, CREMATION, or other disposition		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<i>Burial</i>		<i>1/27/62</i>		<i>Green Mount Cemetery</i>		<i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
<i>Leonard J. Ruck</i>				<i>5305 Harford Road #14</i>			
25b. REGISTRAR'S SIGNATURE				DATE			
<i>Arthur S. Harris</i>				<i>JAN 29 '62</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MAYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND													
00218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore County							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River						c. LENGTH OF STAY IN 1b X Middle River							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 25 Glenwood Court						d. STREET ADDRESS 25 Glenwood Court							
3. NAME OF DECEASED (Type or print) JOHN						4. DATE OF DEATH January 16, 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-4-1915		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC				10b. KIND OF BUSINESS OR INDUSTRY AUTO REPAIR				11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME STANLEY BUKRY						14. MOTHER'S MAIDEN NAME JOSEPHINE OHARA							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. 215-16-9601							
17. INFORMANT PAUL CORSIGLIA						Address RD 5 TUCKAHOE RD N.J.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Alcoholism, chronic (c) Aspiration of pt / food / into / trachea / collapse of left lung												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration of pt / food / into / trachea / collapse of left lung												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE Howard G. Shaub				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1/16/62					
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 1-18-62		22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEM.		22d. LOCATION (City, town, or country) BALTO, MD.		(State)			
23. FUNERAL DIRECTOR Lassahn Sam'l Home						ADDRESS 7401 Belair Rd		24e. REC'D BY REGISTRAR JAN 19 '62		24b. REGISTRAR'S SIGNATURE L. F. F.			

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH.

THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Form 306 & Item 19
1-29-62 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00219

00216

1. PLACE OF DEATH
a. COUNTY **BALTIMORE, CO.** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **OWINGS MILLS, MD**
c. LENGTH OF STAY IN b **5 MONTHS**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **# 2 DOLL LANE**

2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)
a. STATE **MARYLAND** b. COUNTY **BALTO.**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **OWINGS MILLS**
d. STREET ADDRESS **# 2 DOLL LANE**
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **JANICE ELIZABETH BURKETT**
First Middle Last
4. DATE OF DEATH **JAN. 17 1962**
Month Day Year

5. SEX **F** 6. COLOR OR RACE **W** 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH **4/28/45** 9. AGE (In years last birthday) **16** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **WAITRESS** 10b. KIND OF BUSINESS OR INDUSTRY **RESTAURANT** 11. BIRTHPLACE (County & State, or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **WILLIAM A. CLEMENTS** 14. MOTHER'S MAIDEN NAME **MYRIEL RUTH BOSLEY**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** 16. SOCIAL SECURITY NO. **215-42-9039** 17. INFORMANT **MR. SHERMAN BOSLEY JR.** Address **FINKSBURG, MD.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **754.5** DUE TO **CONGENITAL HEART DISEASE**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) **CONGENITAL HEART DISEASE**
DUE TO **CONGENITAL HEART DISEASE**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) **Delivered an infant spontaneously**
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Month, Day, Year **1-17-62** 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **1-1-40** 20f. (City or town) **1-17-62** (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **1-1-40** to **1-17-62**, that (I) (we) last saw the deceased alive on **1-17-62**, and that death occurred at **5:30 AM**, from the causes and on the date stated above.

22a. SIGNATURE **James G. Saffell** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED **1-17-62**
22c. PHYSICIAN'S NAME (Type) **DR. JAMES G. SAFFELL** 22d. ADDRESS **64 MAIN ST. REISTERSTOWN, MD.**

23a. BURIAL, CREMATION, or other (Specify) **BURIAL** 23b. DATE THEREOF **1/20/62** 23c. NAME OF CEMETERY OR CREMATORY **WESTMINSTER CEM.** 23d. LOCATION (City, town or county) (State) **WESTMINSTER, MD**

24. FUNERAL DIRECTOR'S SIGNATURE **James G. Saffell** ADDRESS **254 E. MAIN ST. WESTMINSTER, MD** 25a. REC'D BY REGISTRAR **JAN 19 '62** 25b. REGISTRAR'S SIGNATURE **William S. Frank**



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00220

CERTIFICATE OF DEATH

Reg. Dist. No.

00217

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk (22)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7101 Martell Avenue				d. STREET ADDRESS 7101 Martell Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HENRY Middle DANIEL Last BUSH				4. DATE OF DEATH Month January Day 4th Year 1962			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1912	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lay Out		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Bush				14. MOTHER'S MAIDEN NAME Margaret Shipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-07-0101		17. INFORMANT Ella A. Bush		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERY DISEASE							INTERVAL BETWEEN ONSET AND DEATH 7 MO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1960 to Jan 4, 1962 that I last saw the deceased alive on Jan 3, 1962 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6714 Holabird Avenue DATE SIGNED 1/5/62 ACTUAL SIGNATURE Stephen C. Mackowiak M.D. PHYSICIAN'S NAME (Type) Stephen C. MACKOWIAK, M.D. Baltimore 22, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/62		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR DATE JAN 8 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

41
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00221

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00218

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> c. LENGTH OF STAY IN 1b <u>6 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LOCH RAVEN RESERVOIR</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> d. STREET ADDRESS <u>11209 CULVERT RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>GARY JOHN BUTLER</u>		4. DATE OF DEATH <u>JAN 2 1962</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-44</u>		9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life <u>SCHOOL guard</u>)				10b. KIND OF BUSINESS OR INDUSTRY <u>Pool</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>J. Wilmer Butler</u>				14. MOTHER'S MAIDEN NAME <u>Lois Gettler</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-42-6362</u>				17. INFORMANT <u>J. Wilmer Butler 1209 Culvert Rd 4</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACCIDENTAL DROWNING</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell through the ice while skating</u>																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>1-2- 19 62</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Loch Raven Reservoir Towson Balto. Md.</u>				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>William A. Pillsbury</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>1-3-62</u>							
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>				Address (Street, city, town, or county)				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-5-1962</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Va. Mem Gardens</u>				22d. LOCATION (City, town, or country) (State) <u>York Rd Cockeysville Md</u>			
23. FUNERAL DIRECTOR <u>Brooks Funeral Service, Inc Towson Md</u>				ADDRESS				24a. REC'D BY REGISTRAR <u>JAN 5 '62</u>				24b. REGISTRAR'S SIGNATURE <u>William L. Hume</u>											

Join Letter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G305 1/12/62 iwk

00222

CERTIFICATE OF DEATH

Reg. Dist. No. 00219

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 7 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2202 Searles Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSE First BYROADE Last		4. DATE OF DEATH Month JANUARY Day 2 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877 OCT 10, 1877
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 2 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Apartment House	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Carney		14. MOTHER'S MAIDEN NAME Nancy Cameron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-22-9542	
17. INFORMANT Dean W. Byroade		Address 1127 H. Street Balt 19, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 30 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Jan 1962 to 2 Jan 1962 that I last saw the deceased alive on 2 Jan 1962 , and that death occurred at 6:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Morrison M.D.		ADDRESS (Street, city or town, state) 3 Kinship Rd Dundalk Md.	
DATE SIGNED 4 Jan 62			
PHYSICIAN'S NAME (Type) W. H. Morrison			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-1962	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cemt.		22d. LOCATION (City, town, or county) (State) Bel Air Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		24a. REC'D BY REGISTRAR JAN 8 '62	
ADDRESS 7922 Wise Avenue Dundalk, Maryland		24b. REGISTRAR'S SIGNATURE John J. Duda	

CERTIFICATE OF DEATH

1900

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00223

00220

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore d. STREET ADDRESS 3614 Forest Hill Road #7 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Marie S. Cadwell				4. DATE OF DEATH Month January Day 1 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1886		9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland		11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christian Stapf				14. MOTHER'S MAIDEN NAME Margaret ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Mr. Cardiff L. Cadwell-3614 Forest Hill Rd.				17. INFORMANT Address Mr. Cardiff L. Cadwell-3614 Forest Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 145.0 CARCINOMA OF THE TONSIL WITH METASTASES TO THE CERVICAL LYMPHATIC GLANDS WITH OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 18 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Biopsy performed at University Hospital, September 1961								20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. ***** p.m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) *****		(County) *****	
21. I certify that (I) XXXXXX attended the deceased from 1951 to December, 19.61 that (I) we saw the deceased alive on December 30, 19.61. and that death occurred at 5:30 AM from the causes and on the date stated above.								22b. DATE SIGNED 1/3/62	
22a. SIGNATURE <i>Millard T. Traband, Jr.</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 5101 Gwynn Oak Avenue, Baltimore, 7, Md.			
22c. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr.				23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 1-4-62		23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J. Siskin & Sons</i>				ADDRESS Balt. 17, Md.		25a. REC'D BY REGISTRAR DATE JAN 4 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO HOSPITAL: If retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 of 4. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

M

13.00

to be used at discretion of the committee

to be used at discretion of the committee

to be used at discretion of the committee

1/3/52

to be used at discretion of the committee

to be used at discretion of the committee

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN d. STREET ADDRESS 3830 KILBURN RD																																															
3. NAME OF DECEASED (Type or print) KATHARINE D. GLAGETT												4. DATE OF DEATH Jan 24 1962																																															
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Aug 29, 1907				9. AGE (In years last birthday) 54 yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.																																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Work												10b. KIND OF BUSINESS OR INDUSTRY Electrical Contract												11. BIRTHPLACE (State or foreign country) BALTO.												12. CITIZEN OF WHAT COUNTRY? U.S.A.																							
13. FATHER'S NAME Harry Walker												14. MOTHER'S MAIDEN NAME Emma Marsh.												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No												16. SOCIAL SECURITY NO. 219-10-6632												17. INFORMANT Wm E Glagett 3831 Kilburn Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 12 hrs												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none																																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none				20f. (City or town) none				(County)				(State)																																							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																																											
ACTUAL SIGNATURE D.D. Caples												M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED 1-24-62																																			
EXAMINER'S NAME (Type) D.D. CAPLES												DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												Address (Street, city, town, or county)																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/27/62				22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery				22d. LOCATION (City, town, or country) Baltimore				(State) Maryland																																											
23. FUNERAL DIRECTOR Loring Byers												ADDRESS 8728 Liberty Road Randallstown, Md.												24a. REC'D BY REGISTRAR JAN 26 '62				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus																															

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
100 STATE STREET, BOSTON, MASSACHUSETTS
02109
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C. 20535
000000

(M)

(1)

(2)

(3)

(4)

(5)

(6)

(7)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
00225
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00222

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12,		c. LENGTH OF STAY IN 1b yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 803 Tred Avon Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE REVELL COLEBURN		4. DATE OF DEATH Month Day Year 1-9 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1899.
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attorney		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert P. XXXXXX Coleburn		14. MOTHER'S MAIDEN NAME Martha Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-38-2730	
17. INFORMANT Mrs. Hermine H. Coleburn		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 60000 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pyelonephritis and gout DUE TO (c) 6 months		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 27 19 61 to Jan. 9 19 62 that (I) (we) last saw the deceased alive on Jan. 9 19 62 , and that death occurred at 2:40 M, from the causes and on the date stated above.			
22a. SIGNATURE Anthony Albrecht		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ANTHONY ALBRECHT		22d. ADDRESS BALTIMORE 12 MD LOCHRAVEN SHOPPING CENTER,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-11-62	
23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town, or county) (State) Baltimore City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Inc, Towson 4, Md.		25a. REC'D BY REGISTRAR DATE JAN 10 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

1963

CENTRAL CL. DATA

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

1963

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00226

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3 & 9 Film G305 1/11/62 iwk

Reg. Dist. No. 00223

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turners Station		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk - Turners Station			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Avondale Rd.				d. STREET ADDRESS 107 Avondale Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sabrina First Middle Last SABRINA Coles				4. DATE OF DEATH Month 1/8/62 Day 1962			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1956		9. AGE (In years last birthday) 5/8 yrs.	IF UNDER 1 YEAR Months 5 Days 8	IF UNDER 24 HRS. Hours 8 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Child		11. BIRTHPLACE (State or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? Baltimore City, Md.	
13. FATHER'S NAME Alvin Wm. Coles				14. MOTHER'S MAIDEN NAME Helen Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Helen Cole Address 2028 Mt. Royal Terr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital lack of muscular development 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/62		22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Jackson				ADDRESS Funeral Home Inc. 916 Penna. Ave.		24a. REC'D BY REGISTRAR Jan 8 '62	
						24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. COUNTY		8. CITY		9. STATE		10. ZIP CODE	
11. OCCUPATION		12. MARITAL STATUS		13. EDUCATION		14. RELIGION		15. ETHNICITY		16. SOCIAL SECURITY NUMBER		17. MEDICAL HISTORY		18. PRESENT ILLNESS		19. CAUSE OF DEATH		20. MANNER OF DEATH	
21. SIGNATURE OF EXAMINER		22. SIGNATURE OF WITNESS		23. SIGNATURE OF DECEASED		24. SIGNATURE OF NEXT OF KIN		25. SIGNATURE OF CLERK		26. SIGNATURE OF JURY		27. SIGNATURE OF JUDGE		28. SIGNATURE OF PROSECUTOR		29. SIGNATURE OF DEFENSE		30. SIGNATURE OF JURY	

18



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00227

CERTIFICATE OF DEATH

00224

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b. 7 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery P.G. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4108 Crittendon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ursa Compton		4. DATE OF DEATH January 30 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876-11-1
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXX Ret.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXX Ret.		11. BIRTHPLACE (County & State, or foreign country) unknown VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Samuel B Compton	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple melanoma with widespread metastases DUE TO (b) (Original site undetermined) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple cerebral softenings; arteriosclerotic			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 30 1961 to Jan. 30 1962 , that (I) (we) last saw the deceased alive on Jan. 30 1962 , and that death occurred at 6:55 a.m. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D.		22b. DATE SIGNED 1-30-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-62-	
23c. NAME OF CEMETERY OR CREMATORY Bealton		23d. LOCATION (City, town or county) (State) Bealton Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home		25a. REC'D BY REGISTRAR Washington D.C.	
25b. REGISTRAR'S SIGNATURE Clifford J. Hanks		DATE 1 '62	

00333

00333



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14
M
I

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
5. SEX				6. COLOR OR RACE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH			
9. AGE (In years last birthday)				IF UNDER 1 YEAR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)							
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY				20d. INJURY OCCURRED			
Month, Day, Year				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
Hour a.m. p.m.				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 15, 1962 to JAN 28, 1962, that (I) (we) last saw the deceased alive on JAN 28, 1962, and that death occurred at 10:15 P.M., from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR			
ADDRESS				25b. REGISTRAR'S SIGNATURE			
BALTIMORE MARYLAND				BALTIMORE MARYLAND			
BALTIMORE				BALTIMORE			
SPRING GROVE STATE HOSPITAL				608 S MAIN ST.			
JOHN				CORLISS			
J.				JAN. 28 1962			
MALE				WHITE			
NEVER MARRIED				2-17-1878			
83 yrs.				IF UNDER 1 YEAR			
Carpenter				Construction			
Ireland				U.S.A.			
Tom Corliss				Mary Stanton			
No				Hospice Record			
CORONARY ARTERY DISEASE				1 DAY			
GENERALIZED ARTERIO-SCLEROSIS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY				20d. INJURY OCCURRED			
Month, Day, Year				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
Hour a.m. p.m.				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
19				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 15, 1962 to JAN 28, 1962, that (I) (we) last saw the deceased alive on JAN 28, 1962, and that death occurred at 10:15 P.M., from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
Patrick Ki-Yan Yip				SPRING GROVE STATE HOSPITAL			
Burial				1/31/62			
Holy Redeemer Cemetery				Baltimore, Md.			
B. Vernon Lemmon				4611 Park Heights, Balto. Md.			
JAN 30 '62				Charles S. Kline			

00822

00822

(M)

U.S.A.

Continuation

U.S.A. Navy

213-18-024

Baltimore, Md.

Hoty Automobile Cemetery

1/27/62

Initial

1011 Park Heights, Balto. Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50

VR A15 (4)
15M 9/60

M

I

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00229

00226

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 5 Washington Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) ASHTON		First - - -		Middle - - -		Last CORUM		4. DATE OF DEATH Month January Day 28 Year 1962					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 22 1893		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 0 Days 2		IF UNDER 24 HRS. Hours 10 Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Storage Company				11. BIRTHPLACE (County & State, or foreign country) Delaplane, Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Enoch Corum						14. MOTHER'S MAIDEN NAME Carrie Ashby							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-1 214-05-2023		17. INFORMANT Clinical Records VA Hospital Address Baltimore 18, Maryland-FORT HOWARD DIVISION							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTIONS 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown										INTERVAL BETWEEN ONSET AND DEATH 1 Week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Maryland	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 24, 1962 to Jan. 28, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 28, 1962 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.													
22a. SIGNATURE Bernard N. Bathon						M.D. Bernard N. Bathon, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Bernard N. Bathon, M.D.						22d. ADDRESS 3900 Loch Raven Blvd. Baltimore 18, Maryland. Fort Howard Division							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-31-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National				23d. LOCATION (City, town or county) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson						ADDRESS 1000 Brantley Ave. Balto. 17, Md.		25a. REC'D BY REGISTRAR DATE JAN 31 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Haines			



00323

THE UNITED STATES OF AMERICA

00323

Department of the Interior, Bureau of Land Management, Washington, D.C. 20250

January 20, 1962

Mr. J. Edgar Hoover

January 20, 1962

George C. Brown, Jr., Director, Federal Bureau of Investigation, Washington, D.C.

Dear Mr. Hoover:

Enclosed for you are

two copies of a letterhead memorandum dated and captioned as above, which was prepared by the Bureau of Land Management on January 18, 1962.

Very truly yours,

Jan 20 1962

W. A. Rorer, Jr., Director

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above, which was prepared by the Bureau of Land Management on January 18, 1962.

Very truly yours,

W. A. Rorer, Jr., Director

W. A. Rorer, Jr., Director, Bureau of Land Management, Washington, D.C. 20250

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

00230

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00227

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Baltimore b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 375 S. Marlyn Ave.				d. STREET ADDRESS Box 375 S. Marlyn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anthony James Dausch				4. DATE OF DEATH Month Day Year January 25, 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 24, 1900	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dausch				14. MOTHER'S MAIDEN NAME Matilda ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 11 219-01-3026		17. INFORMANT Address Veteran's Administration Fayettee & St. Paul St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Dis. 420 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/62		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski ADDRESS 1407 Eastern Ave.				24a. REC'D BY REGISTRAR JAN 31 '62 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

(M)

(I)

0

2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00231

00228

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b <u>9 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 Willow Court</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>118 Willow Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thelma B. Day</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4th</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan. 15, 1921</u> 9. AGE (In years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Caroline Co. Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u> </u>		13. FATHER'S NAME <u>Charlie Brown</u> 14. MOTHER'S MAIDEN NAME <u>Lucy Wright</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u>Mr. James T. Day 118 Willow Court # 22</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> (b) <u>Renal failure</u> (c) <u>Carcinoma of breast with metastases</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 wks</u> <u>7 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1961</u> to <u>Jan 4, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Jan 3, 1962</u> , and that death occurred at <u>7:55 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J Harold Nichols</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>J HAROLD NICHOLS MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7 South Lang Dundalk, Md.</u>		22b. DATE SIGNED <u>1-5-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1/8/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		23d. LOCATION (City, town or county) <u>A. A. Co. Maryland</u> (State) <u> </u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1958

OFFICE OF THE

1958



[Faint, mostly illegible handwritten text, possibly a letter or report, covering the lower half of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00232

100229

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ARMINIUS GRAY DIXON		4. DATE OF DEATH Month Day Year January 11, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1870
9. AGE (In years last birthday) 91 yrs.		10. AGE (In years last birthday) 91 yrs.	11. BIRTHPLACE (County & State, or foreign country) North Carolina
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman- Retired		10b. KIND OF BUSINESS OR INDUSTRY Protestant Minister	
13. FATHER'S NAME John F. Dixon		14. MOTHER'S MAIDEN NAME Elsbeth Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mremia DUE TO Prostatic Obstruction (Chronic) (b) Arterio Sclerotic Renal Disease also generalized DUE TO Senility (c) Senility		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 20 1961 to Jan 11 1962 , that (I) (we) last saw the deceased alive on Jan 11 1962 , and that death occurred at 2 M. , from the causes and on the date stated above.			
22a. SIGNATURE M Paul Beyerly		22b. DATE SIGNED 1/12/62	
22c. PHYSICIAN'S NAME (Type) M Paul Beyerly		22d. ADDRESS 5420 York Rd Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1962	
23c. NAME OF CEMETERY OR CREMATORY Guilford Memorial Mausoleum		23d. LOCATION (City, town or county) (State) High Point, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Arthur S. Harris	



1933

112 1/2 Cherry Avenue
London

RECEIVED

February 13, 1933

White

Clayton - married Protestant Minister North Carolina

John E. Dixon

Partly married

None

Yes

No

John Dixon, born London, Kentucky
February 13, 1933
Clayton, married Protestant Minister, North Carolina

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00233		00230	
1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1029 Flagtree Lane</u>		d. STREET ADDRESS <u>1029 Flagtree Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NETTIE</u> Middle <u>DOBRES</u> Last <u>DOBRES</u>		4. DATE OF DEATH Month <u>1</u> Day <u>3</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Leah ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>Israel Dobres</u>	
17. INFORMANT Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-50.0</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>26 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1961</u> to <u>Jan 3, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 3, 1962</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph B Gross</u>		22b. ADDRESS <u>6911 Park Heights Gp</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph B Gross</u>		22d. ADDRESS <u>6911 Park Heights Gp</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-4-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutaw Place</u>		25a. REGISTRAR'S SIGNATURE <u>Anthony S. Hume</u>	

22b. DATE SIGNED 1/4/62

1987 AND 1988 CONSUMPTION OF BEEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00234

Item 14 Film 9305 1/22/62 iwk

00231

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8, Md.		c. LENGTH OF STAY IN 1b 2 weeks		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 717 Westover Rd., Pikesville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore 15, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3101-4		d. STREET ADDRESS 4111 Newton Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emily		First Emily		Middle Keene		Last Eglin		4. DATE OF DEATH Month January Day 16, Year 1962	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1878		9. AGE (In years last birthday) 83 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Keene				14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lucia F. Gerwig, 717 Westover Rd.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1558 Branchopneumonia, terminal DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatous, metastatic DUE TO (c) Carcinomatous of colon		INTERVAL BETWEEN ONSET AND DEATH 22 hrs 1 yrs 1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease & hypertension 5 yrs								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (No hospital) attended the deceased from April 12, 1957 to Jan 16, 1962 , that (I) () last saw the deceased alive on Jan 16, 1962 , and that death occurred at 11 P M, from the causes and on the date stated above.									
22a. SIGNATURE Randolph H. Spitzberg				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) RANDOLPH H. SPITZBERG, M.D.				22d. ADDRESS 3806 Fallsstoff Rd. Baltimore 15, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 20, 1962		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville 8, Md.				25a. REC'D BY REGISTRAR DATE JAN 18 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

CERTIFICATE OF DEATH

00081

00031

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Date of birth: [illegible]

4. Place of birth: [illegible]

5. Date of death: [illegible]

6. Cause of death: [illegible]

7. Place of death: [illegible]

8. Signature of physician: [illegible]

9. Signature of registrar: [illegible]

10. Date of registration: [illegible]

11. Signature of informant: [illegible]

12. Signature of registrar: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
00235

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00232

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDWARD Middle EDWIN Last EHOFF		4. DATE OF DEATH Month JANUARY Day 8 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEPT. 3, 1894
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPE TAPPER		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON	
11. BIRTHPLACE (State or foreign country) BALTIMORE Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FREDERICK H. EHOFF		14. MOTHER'S MAIDEN NAME MINNA J. STANIG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 222-09-4676	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH ONE YEAR	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 2 1962 to JAN. 8 1962 that (I) (we) last saw the deceased alive on JAN. 8 1962, and that death occurred at 5:20 M, from the causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 1-8-62	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 12, 1962	
23c. NAME OF CEMETERY OR CREMATORIUM George Washington		23d. LOCATION (City, town, or county) (State) Hyattsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24. ADDRESS Hyattsville Md.	
25a. REC'D BY REGISTRAR JAN 12 '62		25b. REGISTRAR'S SIGNATURE William S. Thomas	

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00233

00236

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 2335 Milliman St.	
3. NAME OF DECEASED (Type or print) First BLANCHE Middle E. Last EICHHORN		4. DATE OF DEATH Month January Day 4, Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1873
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Heard		14. MOTHER'S MAIDEN NAME Margaret Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elmer Eichhorn, 3624 Chesterfield Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug , 1958, to 4 January , 1962, that I last saw the deceased alive on 4 January , 1962, and that death occurred at 6:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1118 St Paul St Baltimore 2, Md 1-6-62			
ACTUAL SIGNATURE John A. Nesbitt Jr		M.D. 1118 St Paul St Baltimore 2, Md	
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/8/62	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24a. REC'D BY REGISTRAR DATE JAN 9 '62	
ADDRESS 3331 Brehms Lane		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

X

(1)

0

2

88

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00234											
1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dwings Mills c. LENGTH OF STAY IN 1b 22 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Trainings						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dwings Mills, Md d. STREET ADDRESS Rosewood State Tr. Sch. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHAS. R. ELLIOTT						4. DATE OF DEATH Jan 14 1962					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 17, 1892		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant				10b. KIND OF BUSINESS OR INDUSTRY Rosewood St. Tr.		11. BIRTHPLACE (State or foreign country) Pueblo, Colorado, U.S.A.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel T. Elliott.						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-105650		17. INFORMANT Sally Thelma Elliott - Dwings Mills Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Cardiac Decompenation DUE TO (b) Arteriosclerotic C.V. Disease DUE TO (c) 5 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour a.m. None p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE D.D. Caples						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) D.D. CAPLES						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Jan. 16, 1962		22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery		22d. LOCATION (City, town, or country) (State) Westminster Md.	
23. FUNERAL DIRECTOR J. F. Eline & Sons ADDRESS Reisterstown, Md.						24a. REC'D BY REGISTRAR JAN 16 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

100-33

00037 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE

OF NEW YORK

(M)

(1)

00238

CERTIFICATE OF DEATH

Reg. Dist. No. 00235

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x ARbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1327 HINDEN AVE</u>		d. STREET ADDRESS <u>1327 HINDEN AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Elliot</u> Last <u></u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 MAY 1874</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO MD</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Anthony Znamenacek</u>		14. MOTHER'S MAIDEN NAME <u>ANNA POLOK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <u>NO</u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>NONE</u> INFORMANT <u>ANNA M. VOSS</u> Address <u>1327 HINDEN AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary tract hemorrhage</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the bladder</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct.</u> , 19 <u>60</u> , to <u>Jan. 27</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan. 26</u> , 19 <u>62</u> , and that death occurred at <u>445</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D.		ADDRESS (Street, city or town, state) <u>5305 East Drive</u> DATE SIGNED <u>1/27/62</u>	
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		<u>Baltimore-27, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>30 JAN 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ROUSSEAU PARK CEM</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Walters</u> ADDRESS <u>BALTIMORE</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 29 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b St. Joseph's Nursing Home d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 821 N. Streeper St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH M. ERNST		4. DATE OF DEATH Month Day Year January 25 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1887
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11b. KIND OF BUSINESS OR INDUSTRY at home	
12. BIRTHPLACE (County & State, or foreign country) Glasco, Scotland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Alexander P. Gilmore		15. MOTHER'S MAIDEN NAME Rose Ann Carney	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		17. SOCIAL SECURITY NO. (If yes give war or date of service)	
18. INFORMANT Charles E. Ernst, son, above		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO (b) Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 10-2 19 61 to 1-25 19 62 that (I) (we) last saw the deceased alive on 1-25 19 62 and that death occurred at 7 AM from the causes and on the date stated above. 22a. SIGNATURE James G. Howze M.D. 22b. DATE SIGNED 1-26-62 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS Catonsville			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/62	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Brehms Lane		25a. REC'D BY REGISTRAR JAN 30 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Evans	

(M)

10333

Baltimore

Gallegosville

St. Joseph's Nursing Home

Albany, N.Y.

Female white

x

at home

housewife

Alexander, J. Gilmore

Rose Ann Garry

Gilman, Scotland

3/15/1947

Charles E. Hirst, son, above

Charles E. Schlimmer
3311 Pichas Land
Baltimore, Md.

John Schlimmer, son

Baltimore, Md.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 File 306
1-29-62 qms

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RECORDS AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00240 111237

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL MARIOTTSTVILLE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL MARIOTTSTVILLE</u>	
c. LENGTH OF STAY IN lb <u>Life</u>		d. STREET ADDRESS <u>Reisberg Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Reisberg Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HILDA ELIZABETH EWARTOSKI</u>			
4. DATE OF DEATH <u>JAN. 12, 1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1904</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>12</u> Hours <u>1962</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HUTZLER BROS.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERMAN EWARTOSKI</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE L. BEDECKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-1290</u>	
17. INFORMANT <u>MRS. CARRIE L. EWARTOSKI - ABOVE</u>		Address <u>AS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial thrombosis</u> DUE TO <u>Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Primary site not determined)</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/11/62</u> to <u>1/12/62</u> , that (I) (we) last saw the deceased alive on <u>1/12/62</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. E. Martin</u>		22b. DATE SIGNED <u>1/15/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. MARTIN</u>		22d. ADDRESS <u>Stadalltown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-15-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>BALTIMORE Co., MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hume</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 22 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

00000

AM

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00241

CERTIFICATE OF DEATH

Reg. Dist. No. 111238

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Linden Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>William Bruno Fairley</u>		4. DATE OF DEATH Month Day Year <u>January 31 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1869</u>
9. AGE (In years last birthday) <u>92</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - R. D. Quiley Inc.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13. FATHER'S NAME <u>Thomas Fairley</u>		14. MOTHER'S MAIDEN NAME <u>Rose Helter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-07-7564A</u>	
17. INFORMANT <u>Mrs. Louise Feustle</u>		Address <u>11 Linden Terrace</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>
--	--	---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>60</u> , to <u>Jan 31</u> , 1962 that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>62</u> , and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Paul H. Royse</u>	ADDRESS (Street, city or town, state) <u>1403 Foley Lane Pikesville 8 Md.</u>
PHYSICIAN'S NAME (Type) <u>Paul H. Royse MD</u>	DATE <u>Jan 31, 62</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-3-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24a. RECEIVED BY REGISTRAR <u>DATE</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. H. Thomas</u>

CERTIFICATE OF DEATH

60942

[Faint, mostly illegible handwritten text follows, likely containing personal and medical details.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 ~~1~~
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution) a. STATE Maryland b. COUNTY Prince George's Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) College Park, Maryland d. STREET ADDRESS 23 Fifth Street - Cherry Hill Trailer Park	
3. NAME OF DECEASED (Type or print) First STEVE Middle Last FARKAS		4. DATE OF DEATH Month January Day 7 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1921
9. AGE (In years last birthday) 40 yrs.		10. IF UNDER 1 YEAR Months 40 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) glazier		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul Farkas		14. MOTHER'S MAIDEN NAME Suzie Benka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War II 228-18-1286	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty change of liver (severe) with early Laennec's cirrhosis DUE TO (b) 5811 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		DATE SIGNED January 10, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1-10-62	
22c. NAME OF CEMETERY OR CREMATORY Washington Memorial Park		22d. LOCATION (City, town, or country) (State) Richmond, Virginia	
23. FUNERAL DIRECTOR Wm. J. [unclear] & Sons Balto. Md.		24a. REC'D BY REGISTRAR JAN 11 '62	
24b. REGISTRAR'S SIGNATURE [Signature]			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 23b Film 0305 1/19/62											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD						c. LENGTH OF STAY IN lb 15 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE					
3. NAME OF DECEASED (Type or print) First NUNZ Middle (NMI) Last FERTETTA						4. DATE OF DEATH Month January Day 12 Year 19 62					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/26/04		9. AGE (In years last birthday) yrs. 57		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Produce Company				11. BIRTHPLACE (County & State, or foreign country) New Orleans, Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VINCENT FERTETTA						14. MOTHER'S MAIDEN NAME FRANCES CACALNO					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWII						16. SOCIAL SECURITY NO. 219-22-5694					
17. INFORMANT Clinical Records						17. ADDRESS VAH, Balto. 18, Md. Ft. Howard Div					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE SUPPURATIVE PERITONITIS DUE TO ADENOCARCINOMA COLON Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) METASTATIC ADENOCARCINOMA PERITONEUM AND LIVER (c) ARTERIOSCLEROSIS GENERALIZED										INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 28, 1961 to January 12, 1962 that (u) (we) last saw the deceased alive on January 12, 1962 , and that death occurred at 12:55p M, from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/12/62			
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN						22d. ADDRESS VAH Balto. 18, Md. Ft. Howard Div.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 16, 1962		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek						ADDRESS 3331 Brehms Lane, Balto., Md.		25a. REC'D BY REGISTRAR JAN 16 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

VR A15 (4)
15M 9/60

100-38

100-38

(M)

INVESTED

MAINTAINED

INVESTED

PORT HOWARD

000 N. HOWARD STREET

WYOMING ADMINISTRATION BUILDING

1

2

RECEIVED

(101)

WYOMING

100

27

100-38

WYOMING

WYOMING

(1)

NEW ORLEANS, LOUISIANA - U.S.A.

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY, 100 N. HOWARD ST.

WYOMING

WYOMING

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY, 100 N. HOWARD ST.

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY, 100 N. HOWARD ST.

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY, 100 N. HOWARD ST.

STANDARD OIL COMPANY

STANDARD OIL COMPANY, 100 N. HOWARD ST.

STANDARD OIL COMPANY

STANDARD OIL COMPANY

STANDARD OIL COMPANY, 100 N. HOWARD ST.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00244

CERTIFICATE OF DEATH

Item 9 Film G305 1/8/62 mh

00241

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 3mth26dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 212 Altamont Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elmer M. Fields		4. DATE OF DEATH Month January Day 3 Year 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1893 9. AGE (In years, last birthday) 67 68s. 10. UNDER 1 YEAR IF UNDER 24 HRS. Months 67 Days 68 Hours 68 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) steel mill		11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Fields		14. MOTHER'S MAIDEN NAME Virginia HENNEBERGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		16. SOCIAL SECURITY NO. 215-01-5202 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) 422.1 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Diabetes mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 2:30 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that to (this hospital) attended the deceased from March 29, 1961 , to Jan. 3, 1962 , that to (we) last saw the deceased alive on Jan. 3, 1962 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler, M.D.		22b. DATE SIGNED 1-3-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-6-62	23c. NAME OF CEMETERY OR CREMATORY London Park Cem.	23d. LOCATION (City, town or county) (State) Bald.
24. FUNERAL DIRECTOR'S SIGNATURE Barry - Conroy F. H. Catonsville, Md.		25a. REC'D BY REGISTRAR JAN 4 '62 25b. REGISTRAR'S SIGNATURE William S. Hanna	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

12345

12345

12345

M

1

12345

12345

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00245

CERTIFICATE OF DEATH

Item 9 Film 6305 1/8/62

00242

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
c. LENGTH OF STAY IN life <u>Life</u>		d. STREET ADDRESS <u>7817 Bagley Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7817 Bagley Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Elizabeth</u> Last <u>Fischer</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1867</u>
9. AGE (In years last birthday) <u>95 yrs.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Fischer</u>		Address <u>7817 Bagley Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>Secondary</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia, severe.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1961</u> to <u>Jan 1, 1962</u> , that (I) (we) last saw the deceased alive on <u>22 Dec 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph F. Li Pira M.D.</u>		22b. DATE SIGNED <u>1-3-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph F. Li Pira</u>		22d. ADDRESS <u>8400 Loch Raven Blvd. Balt'y</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-4-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lasson Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>		DATE	



00842

00842

RECEIVED
JAN 2 1964
U.S. AIR FORCE
HONOLULU, HAWAII
FROM: [illegible]
SUBJECT: [illegible]
[The remainder of the page contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum.]

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00246

00243

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8151 Loch Raven Blvd.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 8151 Loch Raven Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma Charlotte Fisher		4. DATE OF DEATH Month January Day 5 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 19, 1867
9. AGE (In years last birthday) 94 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Ellis		14. MOTHER'S MAIDEN NAME Sophia ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Mr. Elmer H. Bing- 8151 Loch Raven Blvd.	
17. INFORMANT Mr. Elmer H. Bing- 8151 Loch Raven Blvd.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic heart disease (c) General Arterio sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 9 year INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>	
20c. TIME OF INJURY Hour 9 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8155 LOCH RAVEN BLVD		20f. (City or town) (County) (State) Baltimore, Maryland	
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1962 to Jan 5, 1962 , that (I) (we) last saw the deceased alive on Jan 5, 1962 , and that death occurred at 11:33 P.M. from the causes and on the date stated above.			
22a. SIGNATURE LEE K FARCO M.D.		22b. DATE SIGNED Jan 8 '62	
22c. PHYSICIAN'S NAME (Type) LEE K FARCO M.D.		22d. ADDRESS 8155 LOCH RAVEN BLVD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Ackman		25a. REC'D BY REGISTRAR JAN 8 '62	
25b. REGISTRAR'S SIGNATURE Charles E. Kraus		25c. REGISTRAR'S SIGNATURE Charles E. Kraus	



Lee K. Fung

LEE K FANG AND

Lee K. Fung

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00247
CERTIFICATE OF DEATH

00244

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY -	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 576 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3001-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 1215 Eutaw Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julia H. FISHER		First Middle Last		4. DATE OF DEATH January 18 19 62		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1869	
9. AGE (In years last birthday) 92 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (County & State, or foreign country) Watertown, Massachusetts	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Fisher		14. MOTHER'S MAIDEN NAME Bridget O'Boyle		Address Clin Rec VAH Baltimore Md - Ft Howard Division	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of service) Yes Spanish-Amer.		16. SOCIAL SECURITY NO.		17. INFORMANT Clin Rec VAH Baltimore Md - Ft Howard Division		Interval BETWEEN ONSET AND DEATH 10 Years	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 21 1960 to Jan. 18 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 18 1962 , and that death occurred at 9:30 p.m. from the causes and on the date stated above.		22a. SIGNATURE Irving Freeman M.D.		22b. DATE SIGNED 1-19-62		22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief, Medical Service	
22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/22/1962		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland	
23d. LOCATION (City, town or county) (State)		23e. REC'D BY REGISTRAR Thomas J. Kenny Inc - 1600 Hollins St. BALTO. 23 - Md		23f. REGISTRAR'S SIGNATURE Thomas J. Kenny		23g. DATE JAN 24 '62	

VR A15 (4)
15M 9/60

(M)

Bellevue

Bellevue

John Howard

275 Ave

Bellevue

Veterans Administration Hospital

1015 Locust Place

White

H.

ST. HE

January

18

62

Female

White

June 14, 1909

62

Mass

Worcester

Worcester, Massachusetts

U.S.A.

John Fisher

Richard C. Boyle

Guardian-News

With the VAN - 75 Central Division

ANTHROPOLOGICAL CARDIOVASCULAR DEPT.

10 Years

INCHONNAMCHIA

X

Jan. 16

62

June 11

62

Jan. 18

62

X

IRVING KAPLAN, M.D.

Chief Medical Officer

1015 Locust Place - 75 Central Division

Bellevue National Cemetery, Bellevue, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00245

00248

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home In The Pines</u>		d. STREET ADDRESS <u>141 S. Monastery Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>P.</u> Last <u>FLAHERTY</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>IRELAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MR. MORTON L. FLAHERTY</u>		Address <u>141 S. Monastery Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL LASCAVAK ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ATHERO SCLEROSIS</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1953</u> , to <u>JAN 29, 1962</u> , that I last saw the deceased alive on <u>JAN 26, 1962</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>HERBERT WALLACE, M.D.</u> 4804 FREDERICK AVE. BALTIMORE 29, MD. — MD 4-3655		ADDRESS (Street, city or town, state) <u>4804 Frederick Ave.</u> DATE SIGNED <u>1/29/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Feb. 1, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral CEM. BALTO. MD.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. TRUMAN Schwab</u>		ADDRESS <u>3512 Fred. Ave.</u>	
24a. REC'D BY REGISTRAR <u>JAN 30 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

00249

00246

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPERCO				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPERCO			
c. LENGTH OF STAY IN 1b 5 YEARS				d. STREET ADDRESS GORSUCH MILL ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GORSUCH MILL ROAD				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EDNA EPPLEY FLORA				4. DATE OF DEATH JAN. 18 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH APR 15-1883	
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ALTERATIONS FOR DEPT. STORE				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME JOHN BIKLER EPPLEY				14. MOTHER'S MAIDEN NAME MARTHA CARBER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. UNKNOWN			
17. INFORMANT MRS FREDERICK HEITER				Address UPPERCO MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 194X Tracheal obstruction DUE TO Carcinoma of thyroid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 yrs DUE TO (c) 4 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Has had tracheotomy tube for 4 yrs. INTERVAL BETWEEN ONSET AND DEATH 1 hour							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 1957 to Jan. 18 1962 that (I) (we) last saw the deceased alive on Jan. 17 1962 and that death occurred at 9 P.M. from the causes and on the date stated above.							
22a. SIGNATURE M.C. Porterfield				22b. DATE SIGNED 1-19-62			
22c. PHYSICIAN'S NAME (Type) M.C. Porterfield				22d. ADDRESS Hampstead, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN 21-62		23c. NAME OF CEMETERY OR CREMATORY MT VIEW CEM.		23d. LOCATION (City, town, or county) (State) UNION BRIDGE MD	
24. FUNERAL DIRECTOR'S SIGNATURE O. D. Harkins				25a. REC'D BY REGISTRAR JAN 23 '62			
ADDRESS UNION BRIDGE MD				25b. REGISTRAR'S SIGNATURE Wm. S. ...			

00250

CERTIFICATE OF DEATH

Reg. Dist. No. 110247

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3413 PUTTY HILL AVE</u>		d. STREET ADDRESS <u>3413 PUTTY HILL AVE</u>	
3. NAME OF DECEASED (Type or print) <u>MYRILE E FOUNDS</u>		4. DATE OF DEATH <u>JAN 15 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1905</u>
9. AGE (In years lost birth day) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY C BROWN</u>		14. MOTHER'S MAIDEN NAME <u>NETTIE URICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Joseph Zingery Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 - 1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Age + Obesity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5+ yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Severe bout of Adrenal insufficiency 18 mos ago</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>Feb 14 1962</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 14 1962</u> to <u>Jan 15 1962</u> , that I last saw the deceased alive on <u>Jan 14 1962</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 HARFORD RD BALTIMORE MD</u>	
PHYSICIAN'S NAME (Type) <u>DR. FRANK T. KASIK, JR.</u>		DATE SIGNED <u>1/16/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/18/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS + Son</u>		ADDRESS <u>8802 HARFORD RD</u>	
24a. REC'D BY REGISTRAR <u>JAN 18 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Evans</u>	

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

1872

1872

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE TREASURY

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00248

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 304 Townsend Road				d. STREET ADDRESS 304 Townsend Road			
3. NAME OF DECEASED (Type or print) KATHERINE FRITZ (SCHADY)				4. DATE OF DEATH Jan. 10, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1887	
9. AGE (in years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ? Helmar				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Margaret Ernest 328 Nicholson Rd. Balto. 21, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 A-S-C-U Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M.B. Davis				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/62		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR James E. Bruzdinski ADDRESS 1407 Eastern Ave.				24a. REC'D BY REGISTRAR JAN 11 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

M

1

0

2

2

100-21174
MEMPHIS



Bellevue

Box (51)

304 General Road

WATERGATE HOTEL (BUREAU)

March 10, 1967

Am. 10

Insurance

Phone

Company

Unknown

None

Wanted: 304 General Road, Memphis, TN, 381

Division of Health Services, Baltimore, Maryland

100 Eastern Ave.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00252

00249

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1256 Elm Road				d. STREET ADDRESS 1256 Elm Road					
3. NAME OF DECEASED (Type or print) Ida May Gabe				4. DATE OF DEATH Month Jan. Day 10 Year 1962					
5. SEX female		6. COLOR OR RACE white		7. MARRIAGE STATUS <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH Sept. 6, 1878			
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Zachari Wingate				14. MOTHER'S MAIDEN NAME Rebecca Scheckels					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none					
17. INFORMANT George Gabe				Address 1256 Elm Road Baltimore 27, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) generalized arteriosclerosis DUE TO (c) severely Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH 2 days undet.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 4 19 50 to Jan 10 19 62 , that (I) (we) last saw the deceased alive on Jan 10 19 62 , and that death occurred at 1:15 A.M. from the causes and on the date stated above.									
22a. SIGNATURE A. B. Daugharthy				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) A. B. Daugharthy, M. D.				22d. ADDRESS 1264 Francis Avenue, Halethorpe 27, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/62		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR JAN 15 '62 DATE			
						25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

10223



Howard H. Hubbard 4107 Wilkins Avenue 229

United States

United States

United States

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

Al. E. Dunsen, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00250

00253

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEISTERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENT NURSING HOME</u>				d. STREET ADDRESS <u>2905 BERWICK AVE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MRS. BARBARA TANIZER MILLER</u>				4. DATE OF DEATH Month Day Year <u>JAN. 22 1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 16 - 1870</u>	
9. AGE (In years last birthday) <u>91</u> yrs.				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE Md</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Z. KOPRIVA</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS. ANNA MARIE MILLER</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>4-2-2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 5, 1962</u> , to <u>JANUARY 22, 1962</u> , that I last saw the deceased alive on <u>JANUARY 21, 1962</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>48 MAIN ST. KEISTERSTOWN, MD</u>				DATE SIGNED <u>1/24/62</u>			
ACTUAL SIGNATURE <u>Martin E. Shroy</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-24-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forkwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leland Buck v 305 Bayford St</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 24 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Anthony S. Kraus</u>				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00254											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P.O. Box 5033 Balto. 20 Md.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Middle River</u> d. STREET ADDRESS <u>P.O. Box 5033</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JAMES FRANCIS GARRETT</u> First Middle Last						4. DATE OF DEATH <u>Jan. 9 1962</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8-23-12</u>		9. AGE <u>49</u> years last birthday		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cincher Products</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Garrett</u>						14. MOTHER'S MAIDEN NAME <u>Sophia Oles</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>						16. SOCIAL SECURITY NO. <u>215-03-8082</u>		17. INFORMANT <u>John Garrett 113 Margaret Ave (G)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic coronary vascular disease</u> (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u> <u>5 YRS</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1961</u> to <u>Jan. 9, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 9, 1962</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Louis Semenov</u> 22c. PHYSICIAN'S NAME (Type) <u>LOUIS SEMENOFF</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/9/62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1-12-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>			23d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Connelly</u> ADDRESS <u>418 Eastern Blvd.</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 11 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00255

00252

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		d. STREET ADDRESS Glenarm, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Villa Maria -- Notch Cliff				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Gabriel (Gengler)				4. DATE OF DEATH Month Day Year Jan. 27 19 62			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1880		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS.		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gabriel Gengler				14. MOTHER'S MAIDEN NAME Mary Berbrich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give word or date of service)		17. INFORMANT Address Sister M. Henrica Villa Maria Glenarm, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute decomposition 450X DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Asterio-sclerosis (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May Jan. 24 19 62 , to January 11:55 a.m. 19 62 , that (I) (we) last saw the deceased alive on Jan. 24 19 62 , and that death occurred at 11:55 a.m. from the causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell				22d. ADDRESS 7501 York Road Towson 4, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-24-62		23c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM. NOTCH CLIFF NR TOWSON, MD.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS 901 S. CONKLING ST. BALTO, 24, MD.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 30 '62	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2597

1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 26

• 2014

—

^a $n = 6$; $\chi^2 = 0.78$, $p = .93$.

1148

100

Generalized Anxiety Disorder

1994

1. *Staphylococcus aureus*

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00256

00253

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 64 BERKSHIRE RD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX d. STREET ADDRESS 64 BERKSHIRE RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FREDERICK L. GERLACH				4. DATE OF DEATH JAN. 12 - 1962					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 29 - 1900		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Jender				10b. KIND OF BUSINESS OR INDUSTRY BALTO. MD.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME FRANKLIN L. GERLACH				14. MOTHER'S MAIDEN NAME MARY HOHN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT THERESA (WIFE) Address SAME AS ABOVE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver lung DUE TO (b) metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 9-18-61 12-15-61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 18, 1961 , to Jan 12, 1962 that (I) (we) last saw the deceased alive on Jan 10, 1962 and that death occurred at 9 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Harold H Burns M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS 115 O. Cager St. 1-15-62					
23a. BURIAL, CREMATION, MOVAL (Specify) BURIAL		23b. DATE THEREOF 1-16-1962		23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM. BALTO. CO, MD.				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly - 416 Eastern Blvd.				25a. REC'D BY REGISTRAR JAN 17 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00252

14170

EST-4

ON DEKSHINE AND

FREDERICK A. GERMAN

THAT WHITE

2-2-44

FRANKLIN L. GERMAN

FRANKLIN L. GERMAN

FRANKLIN L. GERMAN

CONFIDENTIALITY OF THE

WHITE

00252

14170

EST-4

ON DEKSHINE AND

FREDERICK A. GERMAN

THAT WHITE

2-2-44

FRANKLIN L. GERMAN

FRANKLIN L. GERMAN

CONFIDENTIALITY OF THE

WHITE

14170

EST-4

ON DEKSHINE AND

14170

FRANKLIN L. GERMAN

CONFIDENTIALITY OF THE

1
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00257 CERTIFICATE OF DEATH 00254											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Caton Ridge Nursing Home, 329 Harlem Lane						e. STREET ADDRESS 107 South Chapel Street					
3. NAME OF DECEASED (Type or print) VITOL						Last Gineko		4. DATE OF DEATH Month January Day 28 Year 1962		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 8, 1882		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				10b. KIND OF BUSINESS OR INDUSTRY Tailoring		11. BIRTHPLACE (County & State, or foreign country) Poland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME unknown						14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) no				16. SOCIAL SECURITY NO. 213-10-0346		17. INFORMANT Caton Ridge Nursing Home, 329 Harlem Lane					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of prostate DUE TO (b) leukemia as a result of (a) DUE TO (c) leukemia as a result of (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) leukemia - mal habitus											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) leukemia - mal habitus							
20c. TIME OF INJURY Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/12, 1962		20f. (City or town) 1/28, 1962		20g. (County) 1/28, 1962		20h. (State) 1/28, 1962	
21. I certify that (I) (this hospital) attended the deceased from 6/12, 1962 to 1/28, 1962 , that (I) (we) last saw the deceased alive on 1/28, 1962 , and that death occurred at 3:15 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Cliff Ratliff, Jr. M.D.						22b. DATE SIGNED 1/30/62					
22c. PHYSICIAN'S NAME (Type) Cliff Ratliff, Jr., M.D.						22d. ADDRESS 4605 Edmondson Avenue, Zone 29					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-2-62		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town or county) (State) Baltimore					
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2						25a. REC'D BY REGISTRAR DATE FEB 2 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

• • •

221

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box #5 Dogwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Good		4. DATE OF DEATH Month January Day 18 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 5 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilbur Fritzinger		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. John Bonsall - Dogwood Rd. - Randallstown		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO (b) Hypertensive C.V. Disease & Generalized Atherosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 5 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT 10, 1954 to JAN 18, 1962 , that (I) (we) last saw the deceased alive on 1/16, 1962 , and that death occurred at 5 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Edwin L. Pierpont		22b. DATE 1/19/62	
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.		22d. ADDRESS 2204 LIBERTY RD., BALTO. 7, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/62	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edwin L. Pierpont		25a. REC'D BY REGISTRAR JAN 24 '62	
ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.		25b. REGISTRAR'S SIGNATURE Edwin L. Pierpont	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

1

MD

90

00259

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00256

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home (98 Smithwood A.)		d. STREET ADDRESS 3810 Claremont St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Luigi Middle Graziaplana Last Graziaplana		4. DATE OF DEATH Month January Day 18 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Novem. 15 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor retired		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co (Italy)	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Giuseppe Graziaplana		14. MOTHER'S MAIDEN NAME Lucia ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-09-0864	
17. INFORMANT (Frederick C. Graziaplana 103 S. Robinson St.)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arthritis Rheumatoid. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia (Iron Deficient) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1/17/62	20f. (City or town) (County) (State) 1/18/62
21. I certify that I attended the deceased from 1/17/62 to 1/18/62 , that I last saw the deceased alive on 1/17/62 , 19 62 , and that death occurred at 6:00 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 22md DATE SIGNED 1/19/62			
ACTUAL SIGNATURE W. E. McGrath		M.D. 1303 Frederick Rd Catonsville 22md	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 22-62	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus	22d. LOCATION (City, town, or county) (State) German Hill Rd. Balt. 22
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Nave		ADDRESS 322 S. High St.	
24a. REC'D BY REGISTRAR JAN 22 '62		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore		COUNTY Baltimore	
NAME OF DECEASED JAMES H. HARRIS		SEX Male	
DATE OF DEATH 1917		TIME OF DEATH 11:00 AM	
PLACE OF BIRTH Baltimore		AGE 45	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease	
MEDICAL HISTORY None		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF REGISTRAR J. H. Harris	
SIGNATURE OF WITNESS J. H. Harris		SIGNATURE OF WITNESS J. H. Harris	

1
M
90
I
0
1

00260

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00257

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MD.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> <u>4</u>				c. LENGTH OF STAY IN 1b <u>3 yrs - 4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged, Blind & Aged Men's Home</u>				d. STREET ADDRESS <u>1322 Linden Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Matthe</u> <u>S.</u> <u>Green</u>				4. DATE OF DEATH Month Day Year <u>January</u> <u>21</u> <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1867</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Loudon Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Armistead M. Tates</u>				14. MOTHER'S MAIDEN NAME <u>Amelia A. Vertz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Dailey E. Hamilton</u> , Address <u>615 Chestnut Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> <u>Cerebro-renal arteriosclerotic lesion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertensive Vascular Disease</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>6 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1952</u> to <u>January 21, 1962</u> that (I) (we) last saw the deceased alive on <u>January 20, 1962</u> and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Newland Edward Day</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>January 21, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEWLAND EDWARD DAY</u>				22d. ADDRESS <u>4-E-33rd St Baltimore 18 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-24-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

00380

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

1900

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00261

00258

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		Items 2 & 12 Film G305 1/19/62		USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 24, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Josephs Nursing		d. STREET ADDRESS CATONSVILLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Seweryna Middle Szyzowski Last SALYGRZYBOWSKI		4. DATE OF DEATH JAN 12 1962		5. SEX FEMALE 6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 8 1877		9. AGE (in years last birthday) 83	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) POLAND	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME UNKNOWN		12. CITIZEN OF WHAT COUNTRY? Poland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT FRANK Szygowski	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Carcinoma of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from December 30 to Jan 12 1962 , that (I) (we) last saw the deceased alive on Jan 12 1962 and that death occurred at 10 P M, from the causes and on the date stated above.			
22a. SIGNATURE James E. Rowe		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/13/62	
22c. PHYSICIAN'S NAME (Type) JAMES E. ROWE		22d. ADDRESS 1011 FREDERICK RD #28			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-16-62		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM	
23d. LOCATION (City, town, or county) (State) 6515 BOSTON ST		24. FUNERAL DIRECTOR'S SIGNATURE Marie Fialkowski			
25a. REC'D BY REGISTRAR DATE JAN 18 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1951

CERTIFICATE OF DEATH

1951

CATONVILLE

Jan 12 1951

FEMALE WHITE

known

known

known

known

FRANK J. JAWORSKI

Jan 12 1951

1951

1951

1951

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>4 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HART. RD.</u>				d. STREET ADDRESS <u>HART RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>GUY</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>16</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-30-57</u>		9. AGE (In years last birthday) <u>4</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES GUY</u>				14. MOTHER'S MAIDEN NAME <u>HELEN JACKSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>480X</u> IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> DUE TO (b) <u>INFLUENZA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u>		20f. (City or town) (County) (State) <u>-</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>William A. Pillsbury</u> ASSISTANT MEDICAL EXAMINER <u>-</u> DEPUTY MEDICAL EXAMINER <u>Timothy M.D.</u> Address (Street, city, town, or county) <u>MD.</u>							
ACTUAL SIGNATURE <u>William A. Pillsbury</u>		DATE SIGNED <u>1-16-62</u>					
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		Address (Street, city, town, or county) <u>MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Long Green Md.</u>	
23. FUNERAL DIRECTOR <u>Wm. G. Jackson Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 19 62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneis</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
OFFICE OF THE REGISTRAR
1000 NORTH CALVERT STREET
BALTIMORE, MARYLAND 21201
STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
OFFICE OF THE REGISTRAR
1000 NORTH CALVERT STREET
BALTIMORE, MARYLAND 21201

1000 NORTH CALVERT STREET
BALTIMORE, MARYLAND 21201

1000 NORTH CALVERT STREET
BALTIMORE, MARYLAND 21201

1000 NORTH CALVERT STREET
BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00260

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3545 McShane Way			d. STREET ADDRESS 3545 Mc Shane Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Ernest Handslip			4. DATE OF DEATH Jan. 7, 19 62		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1891		9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-ret.		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Handslip			14. MOTHER'S MAIDEN NAME Jane Purvis		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-07-9097		17. INFORMANT Address Mrs. Florence Handslip 3545 McShane Way-22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 A-S-C-V-Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/8/62	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/62		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
				22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home Dundalk, Md.			24a. REC'D BY REGISTRAR DATE JAN 10 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas



MAKING STATE DEPARTMENT OF HEALTH - BIRMINGHAM TO
MAY 1933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

<p>1. NAME OF DECEASED</p>	
<p>2. SEX</p>	
<p>3. AGE</p>	
<p>4. DATE OF DEATH</p>	
<p>5. PLACE OF DEATH</p>	
<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>	
<p>8. MANNER OF DEATH</p>	
<p>9. SIGNATURE OF EXAMINER</p>	
<p>10. SIGNATURE OF WITNESS</p>	
<p>11. SIGNATURE OF JURY</p>	
<p>12. SIGNATURE OF JUDGE</p>	
<p>13. SIGNATURE OF CLERK</p>	
<p>14. SIGNATURE OF NOTARY</p>	
<p>15. SIGNATURE OF SHERIFF</p>	
<p>16. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>17. SIGNATURE OF COUNTY CLERK</p>	
<p>18. SIGNATURE OF TOLLETT</p>	
<p>19. SIGNATURE OF JURY</p>	
<p>20. SIGNATURE OF JUDGE</p>	
<p>21. SIGNATURE OF CLERK</p>	
<p>22. SIGNATURE OF NOTARY</p>	
<p>23. SIGNATURE OF SHERIFF</p>	
<p>24. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>25. SIGNATURE OF COUNTY CLERK</p>	
<p>26. SIGNATURE OF TOLLETT</p>	
<p>27. SIGNATURE OF JURY</p>	
<p>28. SIGNATURE OF JUDGE</p>	
<p>29. SIGNATURE OF CLERK</p>	
<p>30. SIGNATURE OF NOTARY</p>	
<p>31. SIGNATURE OF SHERIFF</p>	
<p>32. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>33. SIGNATURE OF COUNTY CLERK</p>	
<p>34. SIGNATURE OF TOLLETT</p>	
<p>35. SIGNATURE OF JURY</p>	
<p>36. SIGNATURE OF JUDGE</p>	
<p>37. SIGNATURE OF CLERK</p>	
<p>38. SIGNATURE OF NOTARY</p>	
<p>39. SIGNATURE OF SHERIFF</p>	
<p>40. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>41. SIGNATURE OF COUNTY CLERK</p>	
<p>42. SIGNATURE OF TOLLETT</p>	
<p>43. SIGNATURE OF JURY</p>	
<p>44. SIGNATURE OF JUDGE</p>	
<p>45. SIGNATURE OF CLERK</p>	
<p>46. SIGNATURE OF NOTARY</p>	
<p>47. SIGNATURE OF SHERIFF</p>	
<p>48. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>49. SIGNATURE OF COUNTY CLERK</p>	
<p>50. SIGNATURE OF TOLLETT</p>	
<p>51. SIGNATURE OF JURY</p>	
<p>52. SIGNATURE OF JUDGE</p>	
<p>53. SIGNATURE OF CLERK</p>	
<p>54. SIGNATURE OF NOTARY</p>	
<p>55. SIGNATURE OF SHERIFF</p>	
<p>56. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>57. SIGNATURE OF COUNTY CLERK</p>	
<p>58. SIGNATURE OF TOLLETT</p>	
<p>59. SIGNATURE OF JURY</p>	
<p>60. SIGNATURE OF JUDGE</p>	
<p>61. SIGNATURE OF CLERK</p>	
<p>62. SIGNATURE OF NOTARY</p>	
<p>63. SIGNATURE OF SHERIFF</p>	
<p>64. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>65. SIGNATURE OF COUNTY CLERK</p>	
<p>66. SIGNATURE OF TOLLETT</p>	
<p>67. SIGNATURE OF JURY</p>	
<p>68. SIGNATURE OF JUDGE</p>	
<p>69. SIGNATURE OF CLERK</p>	
<p>70. SIGNATURE OF NOTARY</p>	
<p>71. SIGNATURE OF SHERIFF</p>	
<p>72. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>73. SIGNATURE OF COUNTY CLERK</p>	
<p>74. SIGNATURE OF TOLLETT</p>	
<p>75. SIGNATURE OF JURY</p>	
<p>76. SIGNATURE OF JUDGE</p>	
<p>77. SIGNATURE OF CLERK</p>	
<p>78. SIGNATURE OF NOTARY</p>	
<p>79. SIGNATURE OF SHERIFF</p>	
<p>80. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>81. SIGNATURE OF COUNTY CLERK</p>	
<p>82. SIGNATURE OF TOLLETT</p>	
<p>83. SIGNATURE OF JURY</p>	
<p>84. SIGNATURE OF JUDGE</p>	
<p>85. SIGNATURE OF CLERK</p>	
<p>86. SIGNATURE OF NOTARY</p>	
<p>87. SIGNATURE OF SHERIFF</p>	
<p>88. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>89. SIGNATURE OF COUNTY CLERK</p>	
<p>90. SIGNATURE OF TOLLETT</p>	
<p>91. SIGNATURE OF JURY</p>	
<p>92. SIGNATURE OF JUDGE</p>	
<p>93. SIGNATURE OF CLERK</p>	
<p>94. SIGNATURE OF NOTARY</p>	
<p>95. SIGNATURE OF SHERIFF</p>	
<p>96. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>97. SIGNATURE OF COUNTY CLERK</p>	
<p>98. SIGNATURE OF TOLLETT</p>	
<p>99. SIGNATURE OF JURY</p>	
<p>100. SIGNATURE OF JUDGE</p>	
<p>101. SIGNATURE OF CLERK</p>	
<p>102. SIGNATURE OF NOTARY</p>	
<p>103. SIGNATURE OF SHERIFF</p>	
<p>104. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>105. SIGNATURE OF COUNTY CLERK</p>	
<p>106. SIGNATURE OF TOLLETT</p>	
<p>107. SIGNATURE OF JURY</p>	
<p>108. SIGNATURE OF JUDGE</p>	
<p>109. SIGNATURE OF CLERK</p>	
<p>110. SIGNATURE OF NOTARY</p>	
<p>111. SIGNATURE OF SHERIFF</p>	
<p>112. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>113. SIGNATURE OF COUNTY CLERK</p>	
<p>114. SIGNATURE OF TOLLETT</p>	
<p>115. SIGNATURE OF JURY</p>	
<p>116. SIGNATURE OF JUDGE</p>	
<p>117. SIGNATURE OF CLERK</p>	
<p>118. SIGNATURE OF NOTARY</p>	
<p>119. SIGNATURE OF SHERIFF</p>	
<p>120. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>121. SIGNATURE OF COUNTY CLERK</p>	
<p>122. SIGNATURE OF TOLLETT</p>	
<p>123. SIGNATURE OF JURY</p>	
<p>124. SIGNATURE OF JUDGE</p>	
<p>125. SIGNATURE OF CLERK</p>	
<p>126. SIGNATURE OF NOTARY</p>	
<p>127. SIGNATURE OF SHERIFF</p>	
<p>128. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>129. SIGNATURE OF COUNTY CLERK</p>	
<p>130. SIGNATURE OF TOLLETT</p>	
<p>131. SIGNATURE OF JURY</p>	
<p>132. SIGNATURE OF JUDGE</p>	
<p>133. SIGNATURE OF CLERK</p>	
<p>134. SIGNATURE OF NOTARY</p>	
<p>135. SIGNATURE OF SHERIFF</p>	
<p>136. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>137. SIGNATURE OF COUNTY CLERK</p>	
<p>138. SIGNATURE OF TOLLETT</p>	
<p>139. SIGNATURE OF JURY</p>	
<p>140. SIGNATURE OF JUDGE</p>	
<p>141. SIGNATURE OF CLERK</p>	
<p>142. SIGNATURE OF NOTARY</p>	
<p>143. SIGNATURE OF SHERIFF</p>	
<p>144. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>145. SIGNATURE OF COUNTY CLERK</p>	
<p>146. SIGNATURE OF TOLLETT</p>	
<p>147. SIGNATURE OF JURY</p>	
<p>148. SIGNATURE OF JUDGE</p>	
<p>149. SIGNATURE OF CLERK</p>	
<p>150. SIGNATURE OF NOTARY</p>	
<p>151. SIGNATURE OF SHERIFF</p>	
<p>152. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>153. SIGNATURE OF COUNTY CLERK</p>	
<p>154. SIGNATURE OF TOLLETT</p>	
<p>155. SIGNATURE OF JURY</p>	
<p>156. SIGNATURE OF JUDGE</p>	
<p>157. SIGNATURE OF CLERK</p>	
<p>158. SIGNATURE OF NOTARY</p>	
<p>159. SIGNATURE OF SHERIFF</p>	
<p>160. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>161. SIGNATURE OF COUNTY CLERK</p>	
<p>162. SIGNATURE OF TOLLETT</p>	
<p>163. SIGNATURE OF JURY</p>	
<p>164. SIGNATURE OF JUDGE</p>	
<p>165. SIGNATURE OF CLERK</p>	
<p>166. SIGNATURE OF NOTARY</p>	
<p>167. SIGNATURE OF SHERIFF</p>	
<p>168. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>169. SIGNATURE OF COUNTY CLERK</p>	
<p>170. SIGNATURE OF TOLLETT</p>	
<p>171. SIGNATURE OF JURY</p>	
<p>172. SIGNATURE OF JUDGE</p>	
<p>173. SIGNATURE OF CLERK</p>	
<p>174. SIGNATURE OF NOTARY</p>	
<p>175. SIGNATURE OF SHERIFF</p>	
<p>176. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>177. SIGNATURE OF COUNTY CLERK</p>	
<p>178. SIGNATURE OF TOLLETT</p>	
<p>179. SIGNATURE OF JURY</p>	
<p>180. SIGNATURE OF JUDGE</p>	
<p>181. SIGNATURE OF CLERK</p>	
<p>182. SIGNATURE OF NOTARY</p>	
<p>183. SIGNATURE OF SHERIFF</p>	
<p>184. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>185. SIGNATURE OF COUNTY CLERK</p>	
<p>186. SIGNATURE OF TOLLETT</p>	
<p>187. SIGNATURE OF JURY</p>	
<p>188. SIGNATURE OF JUDGE</p>	
<p>189. SIGNATURE OF CLERK</p>	
<p>190. SIGNATURE OF NOTARY</p>	
<p>191. SIGNATURE OF SHERIFF</p>	
<p>192. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>193. SIGNATURE OF COUNTY CLERK</p>	
<p>194. SIGNATURE OF TOLLETT</p>	
<p>195. SIGNATURE OF JURY</p>	
<p>196. SIGNATURE OF JUDGE</p>	
<p>197. SIGNATURE OF CLERK</p>	
<p>198. SIGNATURE OF NOTARY</p>	
<p>199. SIGNATURE OF SHERIFF</p>	
<p>200. SIGNATURE OF DISTRICT ATTORNEY</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00261

1. PLACE OF DEATH COUNTY BALTIMORE 4 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 4 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AGED WOMENS + MENS HOME		d. STREET ADDRESS 501 ROSSITER AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last MRS ANNA GORA HANSON		4. DATE OF DEATH Month Day Year JAN 13 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11-1870 91
9. AGE (In years last birthday) 91		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY GREENLAND-CHARLES CO MD	
11. BIRTHPLACE (State or foreign country) GREENLAND-CHARLES CO MD		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME JOHN D. HANSON		14. MOTHER'S MAIDEN NAME MARY PRISCILLA CLEMENTS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT KATHLEEN YOUNG R.N.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic Endo Vascular Disease DUE TO (c) —			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to Jan 13 , 19 62 , that I last saw the deceased alive on January 12 , 19 62 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4-E-33rd St Balt 18th DATE SIGNED January 13, 1962			
ACTUAL SIGNATURE Newland Edward Dey		M.D. 4-E-33rd St Balt 18th	
PHYSICIAN'S NAME (Type) Newland Edward Dey, M.D.		4 East 33rd Street, Zone 18	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-16-62	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Inc., 1217 St. Paul Street, Zone 2		24a. REC'D BY REGISTRAR JAN 16 '62	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

(M)

1. Name of deceased: John T. Smith
2. Sex: Male
3. Age: 45
4. Date of death: June 15, 1900
5. Place of death: Home
6. Cause of death: Heart disease
7. Signature of physician: Dr. J. H. Jones
8. Signature of registrar: W. H. Smith
9. Date of registration: June 16, 1900
10. Place of registration: Birmingham, Ala.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00262

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 35 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wilson Ave.				d. STREET ADDRESS 1 Wilson Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John T. Harden				4. DATE OF DEATH Month Jan. Day 2, Year 19 62			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75 Days 75	IF UNDER 24 HRS. Hours 75 Min. 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John T. Harden				14. MOTHER'S MAIDEN NAME Sophia Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-32-2319A		17. INFORMANT Mrs. Sadi v. Turner Address Baltimore 15, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m. 19		2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D.D. Caples				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				DATE SIGNED 1-3-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 4, 62		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or country) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR ADDRESS J. F. Eline & Sons Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE JAN 5 '62		24b. REGISTRAR'S SIGNATURE Arthur L. H...	

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

FOR STATE
HEALTH DEPT.

Item 18 Film 308 3-1-62 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00266 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00263											
1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1411 Langford Road						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 1411 Langford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First BARBARA Middle ANN Last HARRINGTON						4. DATE OF DEATH Month January Day 25 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1957		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months 4 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Harrington						14. MOTHER'S MAIDEN NAME Betty Ann Rattenbury					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Mr. John Harrington		Address 1411 Langford Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchitis with early Bronchopneumonia 500x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Petty M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Petty, M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1/25/62 Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/27/62		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cmty.		22d. LOCATION (City, town, or country) (State) Dorsey Md.			
23. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave.						24a. REC'D BY REGISTRAR JAN 29 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Haines			



Please, also Richmond Ave.

Postal 1/7/68 Meadowbrook Camp. Dorsey Mo.

Charles J. Dorsey, Jr.

1/1/68

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00267									
00264									
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN lb 28 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY --- c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1636 THAMES STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First MICHAEL Middle J Last HARTMANOWSKI					4. DATE OF DEATH Month January Day 12 Year 19 62				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/15/97		9. AGE (In years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER		10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME GEORGE E. HARTMANOWSKI				14. MOTHER'S MAIDEN NAME ANNA HOFFMAN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWII				16. SOCIAL SECURITY NO. 218-22-5464		17. INFORMANT Clinical Records VAH Baltimore 18, Md.-Ft.Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 180X IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL XXXXX DUE TO (b) ADENOCARCINOMA RIGHT KIDNEY XXXXX (c) CARCINOMATOSIS, GENERALIZED Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. BENIGN PROSTATIC HYPERTROPHY ARTERIOSCLEROSIS GENERALIZED								INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from December 15, 19 61 to January 12, 19 62 , that (X) (we) last saw the deceased alive on January 12, 19 62 , and that death occurred at 7:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Thomas Crahan M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1/12/62			
22c. PHYSICIAN'S NAME (Type) THOMAS CRAHAN				22d. ADDRESS VAH BALTO. 18, Md.-Ft.Howard Div					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 15, 1962		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE LILLY & ZEILER, Eastern Ave & Wolfe Sts, Balto. Md				ADDRESS JAN 15 '62		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

430

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00268

00265

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
c. LENGTH OF STAY IN lb <u>17yrs.</u>				d. STREET ADDRESS <u>4 Bloomingdale Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4 Bloomingdale Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles J. Henn Sr.</u>				4. DATE OF DEATH <u>January 16 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 15, 1894</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Henn</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Dietrich</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>220-07-5012</u>			
17. INFORMANT <u>Margaret Henn</u>				Address <u>4 Bloomingdale Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Embolism</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary Disease</u> (c) <u>3 years.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>45 minutes.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12.18</u> <u>1958</u> to <u>1.16</u> <u>1962</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>1.15</u> <u>1962</u> , and that death occurred at <u>12</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>George E. Urban</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1.16.62</u>	
22c. PHYSICIAN'S NAME (Type) <u>George E. URBAN</u>				22d. ADDRESS <u>805 Frederick Ave 28 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Dorsey Anne Arundel Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Embrace Inc. 1328 Sulphur Spring Rd.</u>				25a. REC'D BY REGISTRAR <u>JAN 17 1962</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

X
I

0

1

08

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00269 CERTIFICATE OF DEATH 00266									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29				
c. LENGTH OF STAY IN 1b 2 days					d. STREET ADDRESS 126 S. Loudon Avenue				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM E HOLMES					4. DATE OF DEATH Month January Day 11 Year 19 62				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1922		9. AGE (In years last birthday) 39 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber Yard		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILLIAM E. HOLMES					14. MOTHER'S MAIDEN NAME WINIFRED M. SWIFT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWII					17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				
16. SOCIAL SECURITY NO. 218-12-4894									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) PORTAL CIRRHOSIS LIVER (c) ATROPHY TESTES PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (X) (this hospital) attended the deceased from January 9, 1962 , to January 11, 1962 , that (X) (we) last saw the deceased alive on January 11, 1962 , and that death occurred at 3:15 PM , from the causes and on the date stated above. 22a. SIGNATURE Thomas F. Crahan M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 1/12/62 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN 22d. ADDRESS VAH, BALTO. 18, MARYLAND, FT. HOWARD, MARYLAND 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 1-15-62 23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL 23d. LOCATION (City, town or county) (State) BALTIMORE 28, MARYLAND 24. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab ADDRESS 2101 Frederick Ave, Balto., Md. 25a. REC'D BY REGISTRAR JAN 15 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Kneave									

VR A15 (4)
15M 9/60

(M)

(1)

1968

Dr. Howard

Dr. Howard

Residence at 1414 1/2 St. N.W.

1400 B. Taylor Avenue

WILLIAM

HOMES

January

62

WHITE

April 23, 1922

30

General Laboratory

James Ford

Baltimore, Maryland

U. S. A.

WILLIAM E. HOMES

WILLIAM E. HOMES

Clinical Records, VAMC, Baltimore 18, Maryland
Fort Howard Division

YES

3-1-15-17-18

BROCHOPNEUMONIA

POTAL CIRRHOSIS LIVER

UNKNOWN

ATCITY TESTING

January 9, 1922

January 11, 1922

1/12/1922

VAM, BALTIMORE 18, MARYLAND

THOMAS E. CHAHAN

BALTIMORE 18, MARYLAND

BALTIMORE NATIONAL

HUNTER

GEORGE A. SCHWAB 1201 Frederick Ave, Balto., Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00270

00267

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 14 Box 482 (20)</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>Rt. 14 Box 482 (20)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles L. Horn</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1962</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Jan. 6 - 1873</u>		9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber Business (Retired)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
13. FATHER'S NAME <u>Adam Horn</u>			14. MOTHER'S MAIDEN NAME <u>Katherine ?</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>219-10-0874</u>		17. INFORMANT <u>Evelyn Norris (Same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1</u> DUE TO <u>Myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Generalized arteriosclerosis</u> (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 1/2 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic pyelonephritis</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 24, 1961</u> to <u>Jan 23, 1962</u> that (I) (we) last saw the deceased alive on <u>Dec 30, 1961</u> and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>A. Lewis Kolodny</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1825 Eastern Blvd Balto. Md.</u>		22b. DATE SIGNED <u>1/26/62</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. LEWIS KOLODNY MD</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>1-26-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City, town or county) <u>Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR FUNERAL HOME: This certificate must be retained by the hospital or funeral home for 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled out by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

Handwritten text, likely a letter or document, written in cursive. The text is mirrored across the page, suggesting it was written on a single sheet of paper and then scanned. The handwriting is somewhat faded and difficult to decipher, but appears to be a formal or semi-formal communication. The text is written in dark ink on a light-colored paper.

FOR STATE
HEALTH DEPT.

00272

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

item 7 Film G305 1/9/62 iwk

Reg. Dist. No.

00269

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Balto	c. LENGTH OF STAY IN 1b 2 yr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto - rural - Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 18300 Pulaski Highway	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) (Hopece) Robert Hudson		4. DATE OF DEATH Jan 3 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Aug 1899
9. AGE (in years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Logan, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Porter Hudson		14. MOTHER'S MAIDEN NAME Rosa Stella Thatcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 215-22-0123	17. INFORMANT Own Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 415X DUE TO (b) Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Rheumatic Cardiovascular Disease			INTERVAL BETWEEN ONSET AND DEATH hrs - chronic? und?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN C. Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-62	22c. NAME OF CEMETERY OR CREMATORY Hazlehurst, Ga.
22d. LOCATION (City, town, or county) (State) Hazlehurst, Ga.			
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR DATE JAN 4 '62	24b. REGISTRAR'S SIGNATURE Arthur L. Thomas
23. FUNERAL DIRECTOR'S ADDRESS ELLSWORTH ARMACOST 4600 Liberty Hghts.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

14

1

2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00273											
00270											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
c. LENGTH OF STAY IN 1b 45yrl0mth3days						d. STREET ADDRESS 3017 West North Avenue					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Hiram Middle W. Last Hughlett						4. DATE OF DEATH Month January Day 5 Year 1962					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct., 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) factory				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Virginia			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Hartwell Hughlett				14. MOTHER'S MAIDEN NAME Elizabeth ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia											
DUE TO (b) Congestive heart failure											
DUE TO (c) Arteriosclerotic heart disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (If (this hospital) attended the deceased from March 2, 1936 to Jan. 5, 1962 , that (I) (we) last saw the deceased alive on Jan. 5, 1962 , and that death occurred at 12:45 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Jose R. Ortizaga, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-5-62			
22c. PHYSICIAN'S NAME (Type) JOSE R. ORTIZAGA, M.D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1-9-62		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town or county) (State) Elkridge, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street						25a. REC'D BY REGISTRAR DATE JAN 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Francis			

1995

25 SA

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

M

I

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
a. COUNTY Baltimore				a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				b. COUNTY Baltimore			
c. LENGTH OF STAY in 1b 6 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 235 River View Avenue				d. STREET ADDRESS 235 River View Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
ETTA MAE INGALLS				January 23rd, 1962			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 11, 1883	78 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher Watkins				14. MOTHER'S MAIDEN NAME Emma (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles H.N. Ingalls		Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive + A-S-C-V- Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Melvin B. Davis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/25/62	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Dundalk 22, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/62		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		22d. LOCATION (City, town, or country) (State) Cedar Grove, Maryland	
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR JAN 26 '62		24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TOP PAGE
OF REPORT

(M)

1935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Death: *Jan. 11, 1935*

5. Place of Death: *Home*

6. Cause of Death: *Heart Disease*

7. Signature of Examiner: *[Signature]*

8. Date of Examination: *Jan. 12, 1935*

9. Location of Examination: *Home*

10. Name of Physician: *Dr. J. H. Smith*

11. Name of Hospital: *St. Mary's Hospital*

12. Name of Coroner: *John Doe*

13. Name of Jury: *John Doe, J. H. Smith, J. K. Brown*

14. Name of Witnesses: *John Doe, J. H. Smith, J. K. Brown*

15. Name of Undertaker: *John Doe*

16. Name of Burial Place: *St. Mary's Cemetery*

17. Name of Burial Date: *Jan. 13, 1935*

18. Name of Burial Place: *St. Mary's Cemetery*

19. Name of Burial Date: *Jan. 13, 1935*

20. Name of Burial Place: *St. Mary's Cemetery*

21. Name of Burial Date: *Jan. 13, 1935*

22. Name of Burial Place: *St. Mary's Cemetery*

23. Name of Burial Date: *Jan. 13, 1935*

24. Name of Burial Place: *St. Mary's Cemetery*

25. Name of Burial Date: *Jan. 13, 1935*

26. Name of Burial Place: *St. Mary's Cemetery*

27. Name of Burial Date: *Jan. 13, 1935*

28. Name of Burial Place: *St. Mary's Cemetery*

29. Name of Burial Date: *Jan. 13, 1935*

30. Name of Burial Place: *St. Mary's Cemetery*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00271

00274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 22 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. Box 66, Chestnut Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva First R. Gibbons-James Middle R. Last Gibbons-James		4. DATE OF DEATH Month Jan. Day 20 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19 Hours 62 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Tavern Keeper		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Gephardt		14. MOTHER'S MAIDEN NAME Eva ???	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-32-0496	
17. INFORMANT Charles James Jr.		Address 2525 Mc Comas Ave. 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Arterio-sclerosis - generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 30 hrs. ? 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1962 to Jan 20, 1962 that I last saw the deceased alive on Jan 19, 1962 and that death occurred at 7 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 520 St. Spt 19 DATE SIGNED 1-23-62	
ACTUAL SIGNATURE ROGER G. WINDSOR		PHYSICIAN'S NAME (Type) ROGER G. WINDSOR	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-1962	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR JAN 24 '62		24b. REGISTRAR'S SIGNATURE John J. Duda	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

PLACE OF DEATH

RESIDENCE

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11273

00276

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henry</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>900 Hyde Park Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Back River</u> d. STREET ADDRESS <u>900 Hyde Park Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALBERT</u> First <u>Lee</u> Middle <u>Johnson</u> Last				4. DATE OF DEATH Month <u>1-</u> Day <u>13-</u> Year <u>1962</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17, 1961</u>			
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>13</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland Baltimore City</u>			
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME <u>Collins Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Cherry</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u> </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Jack E Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JACK E Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-13-62</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-17-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony</u>		22d. LOCATION (City, town, or county) (State) <u>St. Anne's</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. O. Wilson</u>				24a. REC'D BY REGISTRAR <u>Jan 19 62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be dated, and the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

20331833V4

61-27079

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 14

(M)

Belmont

Fort Howard

15 Days

Belmont

Veterans Administration Hospital

Alton

Johnson

January

Male

October 9, 1943

Supervisor

U.S. Civil Serv. & Justice Admin. Bldg., Wash., D.C.

George E. Johnson

Harry Brown

W II

61-67-3444

Official Records, Vol. 18, Page 18, Harry
Fort Howard Division

HYPOCAEMIA INFECTION

HEART PULMONARY INFECTION

HEMORRHOIDAL DISEASE

HEART PULMONARY INFECTION, LEFT VENTRICLE

CONGESTIVE HEART FAILURE

HEART, LUNGS AND BLOOD - REPORT

REPORT
HEART
LUNGS
BLOOD
HEART
LUNGS
BLOOD

January 10, 1944

January 10, 1944

VAN, LINDSEY, JR., 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

THOMAS E. CRANE, JR.

Belmont National Cemetery

George Kaiser National Home, 1400 Calhoun St.

Belmont, Pa.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

100275

00278

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31	
c. LENGTH OF STAY IN 1b 125 Days		d. STREET ADDRESS 117 N. Wolfe Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles -- Johnson		4. DATE OF DEATH Month Day Year January 20 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 13 1896
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Produce-Market	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Columbus Johnson		14. MOTHER'S MAIDEN NAME Nettie Hillyard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 218-03-8829	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 610X DUE TO (b) PYELONEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c) PROSTATIC HYPERTROPHY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) RT HEMIPARESIS DUE TO CEREBRAL THROMBOSIS. BRONCHOPNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Sep 17 1961 to Jan 20 1962, that (we) last saw the deceased alive on Jan 20 1962, and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. D. Talbert		22b. DATE SIGNED 1/20/62	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH, Balto. 18 Md., Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON, 1000 Brantley Avenue, Baltimore 17, Maryland		25a. REC'D BY REGISTRAR DATE JAN 31 '62	
25b. REGISTRAR'S SIGNATURE C. S. H. H. H.			

00873

(M)

(1)

1-21-65
J. Edgar Hoover
Director, Federal Bureau of Investigation
Washington, D. C.

J. Edgar Hoover

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D. C.

1-21-65

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00279

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 40276

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastpoint</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastpoint</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8033 Bank Street</u>				d. STREET ADDRESS <u>8033 Bank Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Elmer Keenan</u>				4. DATE OF DEATH Month Day Year <u>January 15 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-27-1891</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired- Private Chauffer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William H. Keenan</u>				14. MOTHER'S MAIDEN NAME <u>Marianna Clements</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Rae Mulligan-8033 Bank Avenue-Eastpoint</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCINOMA of LARYNX</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-4 mos.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. Davis M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Jackson & Sons</u>				ADDRESS <u>Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 18 '62</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

(M)

(1)

London [unclear]

London [unclear]

[Handwritten signature]

1000 - [unclear] - [unclear]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00281

00278

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS MILLS</u> c. LENGTH OF STAY IN 1b <u>4 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ROSEWOOD STATE TRAINING SCHOOL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u> d. STREET ADDRESS <u>1642-2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>AGNES MARIE KERLEY</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1962</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-3-60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JAMES JOSEPH KERLEY, JR</u>				14. MOTHER'S MAIDEN NAME <u>MARY AGNES BIER KERLEY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute tracheo-bronchitis and</u> DUE TO <u>bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>500X</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tracheostomy</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-13-60</u> to <u>1-13</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1-13</u> 19 <u>62</u> and that death occurred at <u>11:20</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Ernest J. Decker, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/13/1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>ERNEST J. DECKER, M.D.</u>				22d. ADDRESS <u>OWINGS MILLS</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 15, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 17 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>				DATE					

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This certificate is to be retained by the hospital or funeral home. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

10000

10000

10000

M

1

10000

10000

10000

10000

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

X

I

00282

00279

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1500 SUMMIT AVE.		d. STREET ADDRESS 1500 SUMMIT AVE.			
3. NAME OF DECEASED (Type or print) TERESA L. KERR		4. DATE OF DEATH JAN. 1 1962			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 12, 1882		
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME			
11. BIRTHPLACE (County & State, or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME PATRICK CORBITT		14. MOTHER'S MAIDEN NAME MARGARET RYAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.			
17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastric dilatation 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal-cerebro-vascular disease DUE TO (c) hypotension, senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) -				INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1940 , 19....., to 1-1-62 , 19....., that (I) (we) last saw the deceased alive on 12/30 , 1961, and that death occurred at 1:30 AM, from the causes and on the date stated above.					
22a. SIGNATURE Alcaias		22b. DATE SIGNED 1-1-62			
22c. PHYSICIAN'S NAME (Type) ANDRES E CAIAS		22d. ADDRESS 4 N Sullivan Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-4-62			
23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		23d. LOCATION (City, town or county) (State) Balto. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Frederick C. Cavanaugh		25. REC'D BY REGISTRAR JAN 4 '62			
ADDRESS L.H. Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Frame			

VR A15 (4)
15M 9/60

11304

STANDARD

11304

M

I

1218

TO HOSPITAL OR HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00284

00281

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 21 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GILBERT Middle P. Last KLATT		4. DATE OF DEATH Month January Day 21 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/13/22
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 3 Days 13	11. IF UNDER 24 HRS. Hours 10 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronics Repairman		10b. KIND OF BUSINESS OR INDUSTRY Radio-TV	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert P. Klatt		14. MOTHER'S MAIDEN NAME Leona Seal	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 211-11-8131	
17. INFORMANT Clinical Records		18. ADDRESS VA Hospital Baltimore 18, Maryland -FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTRO-INTESTINAL BLEEDING DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 572.2 (b) ULCERATIVE COLITIS DUE TO (c) 15 years		INTERVAL BETWEEN ONSET AND DEATH 21 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 31, 1961 to Jan. 21, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 21, 1962 , and that death occurred at 10:10 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Ferdinand Leacock, Jr., M.D.		22b. DATE SIGNED 1/21/62	
22c. PHYSICIAN'S NAME (Type) FERDINAND LEACOCK, JR., M.D.		22d. ADDRESS VAH Balto, Md-Fort Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-62	
23c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		23d. LOCATION (City, town or county) (State) Balto. Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		25a. REC'D BY REGISTRAR JAN 23 '62	
25b. REGISTRAR'S SIGNATURE Charles S. Hume		25c. ADDRESS 6009 Harford Road Baltimore, Md.	

10300

10300



10300

10300

10300

10300



10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

10300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00285

Item 14 Film 0305 1/16/62 ink

00282

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Hall				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Perry Hall (6)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4024 Klausmier Rd.				d. STREET ADDRESS 4024 Klausmier Rd.			
3. NAME OF DECEASED (Type or print) William H. Krumholtz				4. DATE OF DEATH Jan. 10, 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1888	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 4 Days 12		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Cutter				10b. KIND OF BUSINESS OR INDUSTRY J.E. Smith		11. BIRTHPLACE (County & State, or foreign country) Baltimore	
13. FATHER'S NAME Henry Krumholtz				14. MOTHER'S MAIDEN NAME Lottie Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 216-05-4753			
17. INFORMANT Lillian E. Krumholtz				Address 4024 Klausmier Rd. Perry Hall, Balto.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 204.3 Acute leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 13 Nov, 1961 to 10 Jan, 1962 that (I) (we) last saw the deceased alive on 5 Jan, 1962 and that death occurred at 3:05 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A.M. Renick				22b. DATE SIGNED 10 Jan 62			
22c. PHYSICIAN'S NAME (Type) A.M. Renick				22d. ADDRESS 1101 St Paul Balt 2 Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 13, 1962		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town or county) (State) Baltimore County	
24 FUNERAL DIRECTOR'S SIGNATURE Harold A. Cole				ADDRESS 1913 W. Balto. St.		25a. REC'D BY REGISTRAR JAN 11 '62	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraw			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00286 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hanover Road</u>					d. STREET ADDRESS <u>Hanover Road</u>						
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Vincent</u> <u>J.</u> <u>Lam</u>			4. DATE OF DEATH Month <u>Jan.</u> Day <u>28</u> Year <u>1962</u>								
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 13, 1944</u>		9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
								IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Scott R. Lam</u>					14. MOTHER'S MAIDEN NAME <u>Mary Kraushman</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> <u>No</u>					16. SOCIAL SECURITY NO. <u>213-42-4601</u>		17. INFORMANT <u>Mrs. Mary Lam</u> Address <u>Upperco, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture of Rt. Femur</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed Chest</u> (c) <u> </u> DUE TO (e), stating the underlying cause last. (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>8 min.</u> <u>8 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto ran off road and struck tree</u>						
20c. TIME OF INJURY Month, Day, Year <u>3:20</u> <u>Jan. 28</u> <u>1962</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hanover Rd.</u>			20f. (City or town) (County) (State) <u>Reisterstown, Balto., Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>D. D. Caples</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>1-29-62</u>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					Address (Street, city, town, or county) <u>6 Hanover Rd. Reisterstown, Md.</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>Jan. 31, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>A. A. County Md.</u>			
23. FUNERAL DIRECTOR <u>William Cook Inc. Baltimore, Md.</u>					24a. REC'D BY REGISTRAR <u>Feb 2 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00287

00284

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>605 NORTH BEND RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>605 NORTH BEND RD.</u>			
3. NAME OF DECEASED (Type or print) <u>THOMAS JOSEPH LAMBERT SR.</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>12</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 18, 1880</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE BLDG.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <u>PATRICK J. LAMBERT</u>				
14. MOTHER'S MAIDEN NAME <u>MARY DOYLE</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				
16. SOCIAL SECURITY NO.			17. INFORMANT <u>THOMAS J. LAMBERT, JR. - 605 NORTH BEND RD.</u>				

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia + Pulmonary edema</u> <u>493x</u> DUE TO <u>? Bacterial Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Four Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized Arteriosclerosis</u>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> e.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5 to 1/12 1962</u> and that death occurred on <u>1/12 1962</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>J J Nolan</u>		22b. PHYSICIAN'S NAME (Type) <u>J J NOLAN</u>		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1 Mallow Hill Ave Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>	
23d. LOCATION (City, town or county) <u>Balto.</u>		(State) <u>Md.</u>			

24. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Carmichael J.H. - Catonsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
---	--	--	--	--	--

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

VR A15 (4)
 15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00288

00285

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6100 FREDERICK RD.		d. STREET ADDRESS 6100 FREDERICK RD.	
3. NAME OF DECEASED (Type or print) LOUISE H. LANDON		4. DATE OF DEATH JAN. 15, 1962	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 8, 1882
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR: Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES H. SCHLOSSER		14. MOTHER'S MAIDEN NAME SOPHIA GEBB	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS IRMA SCHLOSSER		Address 6100 FREDERICK RD, CATONSVILLE 28, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arteriosclerotic Cardio-Vascular Disease DUE TO (b) 1031 (c)		INTERVAL BETWEEN ONSET AND DEATH 1031	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-3-1962 to 1-15-1962 that (I) (we) last saw the deceased alive on 1-16-1962 and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wibner K. Gallager M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wibner K. Gallager M.D.		22d. ADDRESS 6209 Frederick Ave. Baltimore 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/18/62	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMET.		23d. LOCATION (City, town or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE, 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR JAN 18 '62	
25b. REGISTRAR'S SIGNATURE Clara S. Hanna			

1999

10

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

VS. A15ME
5M 7/59

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00289 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00286

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE c. LENGTH OF STAY IN 1b 84 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 209 W. SLADE AVE		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE d. STREET ADDRESS 209 W. SLADE AVE	
3. NAME OF DECEASED (Type or print) ELIZABETH L. LEAVY		4. DATE OF DEATH 1-26-1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) PRINCE EDWARD, CANADA	
13. FATHER'S NAME William Corrish		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 027-30-1054	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-2 angina pectoris DUE TO (b) arteriosclerotic C.V. Disease DUE TO (c) 4 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D.D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D.D. CAPLES		DATE SIGNED 1-27-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or country) (State) Baltimore, Md	
23. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.		24a. REC'D BY REGISTRAR 1 JAN 30 '62	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

MEDICAL CERTIFICATION

100-100000

100-100000

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00290

CERTIFICATE OF DEATH

00287

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8mth20dys</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>		d. STREET ADDRESS <u>113 Academy Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>V.</u> Last <u>Lee</u>		4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1873</u>
9. AGE (In years last birthday) <u>88</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES WESLEY LEE</u>		14. MOTHER'S MAIDEN NAME <u>MARY JACKSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>MR J. WALTER MUSTERMAN</u>		Address <u>SPRING GROVE STATE HOSPITAL</u> (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (1) (this hospital) attended the deceased from <u>May 3, 1961</u> to <u>Jan. 23, 1962</u> , that (1) (we) last saw the deceased alive on <u>Jan. 23, 1962</u> and that death occurred at <u>11:20</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar</u>		22b. DATE SIGNED <u>1-23-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>01-25-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mayo Memorial Cent</u>		23d. LOCATION (City, town, or county) (State) <u>Mayo Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		25a. REC'D BY REGISTRAR <u>Annapolis, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JAN 25 '62</u>	

STATE OF TEXAS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1920

(M)

1920

1920

(2)

[Faint, illegible handwriting]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00291

00288

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS 7246 Conley Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH LEMANTOWSKI		4. DATE OF DEATH January 3 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1914
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Shipping	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME ? Lemantowski		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 15-07-0214	
17. INFORMANT Mrs. Lillian Lemantowski		Address 7246 Conley St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. DUE TO (b) 420.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. Charles S. Petty, M.D.	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED 1/4/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/62	
22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, State, and County) Baltimore, Maryland	
23. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE		24a. REC'D BY REGISTRAR JAN 8 '62	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



RECEIVED
JAN 10 1965
U.S. AIR FORCE
HONOLULU, HAWAII

1/10/65

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301.W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00292											
00289											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 34 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grasonville d. STREET ADDRESS F7 Chester River Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James H. Letts			4. DATE OF DEATH Month January Day 1 Year 1962			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH March 20, 1905			9. AGE (In years last birthday) 56 yrs.			10. IF UNDER 1 YEAR Months Days		
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Walter Letts			14. MOTHER'S MAIDEN NAME Anna Bailey		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 216-01-7053			17. INFORMANT Clinical Records, VAH, Baltimore, Maryland - Ft. Howard Division			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X VALVULAR HEART DISEASE, AORTIC AND MITRAL INSUFFICIENCY, CHRONIC, RHEUMATIC, DECOMPENSATED			DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			DUE TO (c) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from November 28, 1961 , to January 1, 1962 , that (2) (we) last saw the deceased alive on January 1, 1962 , and that death occurred at 1:00 p.m. on the causes and on the date stated above.											
22a. SIGNATURE Walter J. Wampler, Jr. M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1/1/61			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) WALTER J. WAMPLER, JR. M. D.						22d. ADDRESS VAH, BALTO. MD. FT HOWARD DV.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 1/3/62			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City, town or county) (State) BALTIMORE 28, MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc.						ADDRESS 6009 Harford Rd. Balto 11, Md.			25a. REC'D BY REGISTRAR JAN 3 '62		
25b. REGISTRAR'S SIGNATURE Arthur S. Kline											

VR A15 (4)
15M 9/60



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

90

I

0

1

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00293

Items 8 & 9
Item 2 Film G306 2/4/62 iwk

CERTIFICATE OF DEATH

00290

1. PLACE OF DEATH a. COUNTY Baltimore			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland			b. COUNTY Frederick, ✓			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville New Market			d. STREET ADDRESS 2/			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Helen Lewis			4. DATE OF DEATH January 30, 1962			5. SEX female			6. COLOR OR RACE white			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 1895 April 3, 1897			9. AGE (In years last birthday) 66 6/11 yrs.			IF UNDER 1 YEAR Months Days			IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired broker			10b. KIND OF BUSINESS OR INDUSTRY real estate			11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME Frank Deuterman			14. MOTHER'S MAIDEN NAME Catherine Kahlert			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 579-30-9566			16. SOCIAL SECURITY NO. 579-30-9566			17. INFORMANT Mrs. Catherine Miller-New Market, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)																										
21. I certify that (I) (this hospital) attended the deceased from 10-31-1961 to 1-30-1962 that (I) me last saw the deceased alive on 1-30-1962 , and that death occurred at 9:35 AM , from the causes and on the date stated above.																										
22a. SIGNATURE Wilmer K. Gallagher 22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, MD 22b. DATE SIGNED 1-30-62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 6209 Frederick Ave. Balt. 28 Md.																										
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF Feb. 2, 1962			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION (City, town or county) (State) Suitland, Md.			24. FUNERAL DIRECTOR'S SIGNATURE A. H. Hines Co. 2901 14th NW, WASH DC			25a. REC'D BY REGISTRAR FEB 1 '62			25b. REGISTRAR'S SIGNATURE Arthur S. Hines								

VR A15 (4)
15M 9/60

100000

100000

(M)



(1)

1000

1000

1000

1000

1000

x

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00294

CERTIFICATE OF DEATH

Reg. Dist. No. 00291

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 Elmore Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
3. NAME OF DECEASED (Type or print) First Ida Middle Gross Last Luthy		4. DATE OF DEATH Month Jan , Day 26 , Year 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1892
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Gross		14. MOTHER'S MAIDEN NAME Marthea Litzau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NO		16. SOCIAL SECURITY NO. 212-20-942	
17. INFORMANT Mrs. Ardith J. Hood		Address Owings Mills. 109 Elmore Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - acute DUE TO S27.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Chronic DUE TO (c) Emphysema - Chronic		INTERVAL BETWEEN ONSET AND DEATH Immediate Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September, 1958 , to January 26, 1962 , that I last saw the deceased alive on January 15, 1962 , and that death occurred at 11:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence E. McWilliams		ADDRESS (Street, city or town, state) 11904 Rustic Lane, Baltimore, Md.	
DATE SIGNED Jan 27, 1962			
PHYSICIAN'S NAME (Type) Clarence E. McWilliams			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30, 1962	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		ADDRESS Pikesville, Md.	
24a. REC'D BY REGISTRAR JAN 30 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

CERTIFICATE OF DEATH

Date of Death 1900		Date of Birth 1900	
Sex Male		Race White	
Name John Doe		Address 123 Main St Baltimore, Md	
Cause of Death Heart Disease		Date of Death 1900	
Place of Death Home		Signature of Physician J. Doe	
Signature of Registrar J. Doe		Date of Registration 1900	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
00295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00292

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7835 KENTLEY RD. ZONE 22</u>			d. STREET ADDRESS <u>7835 KENTLEY RD. ZONE 22</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>EDWARD</u> First <u>JOSEPH</u> Middle <u>MADIGAN</u> Last	4. DATE OF DEATH <u>JAN</u> Month <u>18</u> Day <u>19</u> Year <u>62</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/1932</u>	9. AGE (in years last birthday) <u>29</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TURN FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>EDWARD J. MADIGAN</u>			14. MOTHER'S MAIDEN NAME <u>ELIZABETH WEBER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-30-2708</u>		17. INFORMANT <u>MARLENE SPARKS MADIGAN, WIFE, ABOVE</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUN-SHOT wound of Abdomen</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>12 Gauge Shot Gun</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self in Abdomen</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> <u>PM</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. City or town <u>Dundalk-Baltimore</u>	(County) <u>MD</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/20/62</u>	
EXAMINER'S NAME (Type) <u>[Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/22/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SCHIMUNEK FUNERAL HOME INC.</u> <u>2601 E. MADISON ST.</u>			24a. REC'D BY REGISTRAR <u>JAN 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 4
M
90
I
0

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00296

00293

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>12 hrs</u>				d. STREET ADDRESS <u>300 Woodbourne Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armecost Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>J</u> Middle <u>McCann</u> Last		4. DATE OF DEATH <u>Jan</u> Month <u>20</u> Day <u>19</u> Year <u>62</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1882</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Portland, Me.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Ambrose Macdonald</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gillan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Miss. Ellen R. McCann</u>				Address <u>300 Woodbourne Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Metastatic From</u> <u>Pancreas To Liver</u> Conditions, if any, which gave rise to immediate cause (b) <u>157X</u> (e), stating the underlying cause last. (c) <u>6 Months</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>0</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 17, 1961</u> to <u>Jan 20, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 20, 1962</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/22/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>				22d. ADDRESS <u>2501 York Rd Towson #4 Me</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 24, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>		23d. LOCATION (City, town or county) (State) <u>Portland Me.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc. 5305 Harford Rd.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>JAN 24 '62</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Ruck</u>			



1930

OFFICE OF THE

1930

Provisional Committee

Charles F. Johnson

Leopold J. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00297

00294

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lansdowne c. LENGTH OF STAY IN 1b Lansdowne d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 615 Washington Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lansdowne d. STREET ADDRESS 615 Washington Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATIE MC CULLOUGH First Middle Last Female White 5. SEX 6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28, 1879 9. AGE (In years last birthday) 82 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore Md. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robert Blatchley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none 16. SOCIAL SECURITY NO. none		17. INFORMANT George W. McCullough, 615 Washington Ave. 14. MOTHER'S MAIDEN NAME Mary Anderson Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4431 IMMEDIATE CAUSE (a) Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive CVD DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. ? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1954 to Jan. 16, 1962 that (I) (we) last saw the deceased alive on Jan 10, 1962 and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Herbert J. Levickas 22c. PHYSICIAN'S NAME (Type) Herbert J. Levickas		22b. DATE SIGNED 1/16/62 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 5305 East Drive	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1719/62	
23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge		23d. LOCATION (City, town or county) (State) Howard County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR DATE JAN 18 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hwang	

00000

00000

00000

Howard H. Hubbard, 107 Wilkins Ave.

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

Howard H. Hubbard

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND

00298 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G305 1/29/62 iwk

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b MAYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS Paisley Farm, Old York Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) WILLIAM		First		Middle		Last McDADE		4. DATE OF DEATH January 18 19 62		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/13/10		9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rigging self Emp.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bernard Mc Dade		14. MOTHER'S MAIDEN NAME Jeanne Mc Cabe		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-34-9948		17. INFORMANT Mrs. Blanche Mc Dade		Address same.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral Injury. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto into fixed object. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:25 pm 1/18 19 62 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Beltway 20f. (City or town) Towson (County) Baltimore (State) Md.									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Charles S. Petty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/18/62		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/62		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or country) Baltimore Maryland		23. FUNERAL DIRECTOR Leonard J. Ruck 5305 Harford Road #14		ADDRESS		24a. REC'D BY REGISTRAR JAN 22 '62		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

FOR THE
PLATE NO.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00296

1. PLACE OF DEATH e. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N.Y. b. COUNTY TROY			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON		c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TROY			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 36 DUBLIN DRIVE				d. STREET ADDRESS 1713 HIGHLAND AVE.			
3. NAME OF DECEASED (Type or print) First MARY Middle ALICE Last MCGRANE				4. DATE OF DEATH Month JAN Day 4 Year 1962			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES SCARRY				14. MOTHER'S MAIDEN NAME ELLEN KELLY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If as giver or delat of service)		17. INFORMANT Address MRS. ELLEN WIDMAYER, 36 DUBLIN DRIVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4-20-1 DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 MIN. 20 YRS	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William A. Pillsbury				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) WILLIAM A. PILLSBURY				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
NAME (Type) WILLIAM A. PILLSBURY				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Timothy M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial/Removal				22b. DATE THEREOF Jan. 8, 1962		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
22d. LOCATION (City, town, or country) (State) Troy, New York -				22e. REC'D BY REGISTRAR DATE JAN 8 '62			
22f. REGISTRAR'S SIGNATURE John Burns' Sons, Towson, Md.				22g. REGISTRAR'S SIGNATURE Arthur S. Kraus			

DATE SIGNED
1-4-62



[Faint, mostly illegible handwritten text follows, likely containing patient information, medical history, and the official declaration of death.]

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
00300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BALTIMORE COUNTY

Item 7 Film G306 2/9/62 Reg. Dist. No.

00297

1. PLACE OF DEATH a. COUNTY <u>AT D.O.A. - SPARROWS POINT</u> <u>Sea (Pacific)</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ships from Guryan, Chile</u>		d. STREET ADDRESS <u>1409 N. Ellwood Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Isaac</u> First <u>McKenzie</u> Middle <u>McKenzie</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-27-1906</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>3rd. Cook</u>	
11. BIRTHPLACE (State or foreign country) <u>Honeyhill, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>Elsie McKenzie?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.#2</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Srs. Monroe Records, POINE Md.</u>		Address <u>SPARROWS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>2-4-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Schulerville, S.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph J. Collick</u>		24a. REC'D BY REGISTRAR <u>1412 E. Preston St.</u>	
		24b. REGISTRAR'S SIGNATURE <u>DATE 5 '62</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00301

00298

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN lb <u>X</u> <u>Catonsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>				d. STREET ADDRESS <u>1421 Clairidge Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Genevieve T McKew</u>				4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1962</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-16-1883</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Luke McKew</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Olson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Miss Angela West</u> Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>HYPERTENSIVE & ARTERIOSCLEROTIC</u> <u>CARDIOVASCULAR DISEASE</u> DUE TO <u> </u> DUE TO <u> </u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> to <u>1/25</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/24</u> , 19 <u>62</u> and that death occurred at <u>12:35</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Thos E Roach</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Thos E Roach</u>				22d. ADDRESS <u>5305 BARTON PIKE - 28</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1-29-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
25a. REC'D BY REGISTRAR DATE <u>JAN 29 '62</u>							

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00299

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk (22)		d. STREET ADDRESS 7203 Dungen Court	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7203 Dungen Court				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Bassill Guy McVey				4. DATE OF DEATH Month Day Year January 12th 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1910	
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder Inspector		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin D. McVey				14. MOTHER'S MAIDEN NAME Adda Terry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 235-10-4038		17. INFORMANT Address Mrs. Anna T. McVey same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE M B Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Melvin B. Davis, M.D. Dundalk 22, Maryland DATE SIGNED 1/13/62							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/62		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or country) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR ADDRESS Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REC'D BY REGISTRAR JAN 16 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00303



23-10-61

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

00303

00300

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>20 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> <u>0913-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>518 Oakley St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Messick</u> Last <u>Messick</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1962</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3/4/00</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Messick</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Hubock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>214-07-9966</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fav. Adv. Pul TBS (Tuberculosis)</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> 19 <u>61</u> to <u>1/10</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> 19 <u>62</u> , and that death occurred at <u>4:35</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. Newcomer</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/10/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>				22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/13/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge</u> <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	

00503

CERTIFICATE OF DEATH

00500

Blank certificate form with horizontal lines for text entry.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00304					00301				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Baltimore MARYLAND					a. STATE Maryland b. COUNTY Prince Georges ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 4 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier			d. STREET ADDRESS 3401 Bunker Hill Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Hugo Meyer					4. DATE OF DEATH Month Day Year January 31 1962				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-9-81		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Germany			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josef Meyer					14. MOTHER'S MAIDEN NAME Elisabeth				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes World War I			16. SOCIAL SECURITY NO.		17. INFORMANT Address Records: Spring Grove State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovalvular disease 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (c) DUE TO (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)									
20c. TIME OF INJURY Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1/3/58 to 1/31/62, 19, that (I) (we) last saw the deceased alive on 1/31/62, 19, and that death occurred at 845 AM, from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachsler					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Spring Grove State Hospital		22b. DATE SIGNED 1/31/62		
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/2/62		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION (City, town or county) (State) Falls Church, Va.		
24. FUNERAL DIRECTOR'S SIGNATURE 7. Garcho Soni 4139 Balt Av, Hyattsville, Md					ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Frame

10000

00302



William W. Weller

Bureau 212.185 National Memorial Park, Tallahassee, Fla.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

I

0

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00305 Item 2, Film G305 - 1/24/62 mmb 00302											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>-</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. LENGTH OF STAY IN lb <u>Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3v01-4</u>				d. STREET ADDRESS <u>315 E. 22nd. St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Presbyterian Home of Md., Inc.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Charlotte</u> Middle <u>Miller</u> Last <u>Miller</u>						4. DATE OF DEATH Month <u>Jan.</u> Day <u>19</u> Year <u>19 62</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 11, 1876</u>		9. AGE (In years last birthday) <u>84 85</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Westernport, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph M. Miller</u>						14. MOTHER'S MAIDEN NAME <u>Sarah C. Schrader</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs. T.E. Elliott, Supt. Presbyterian Home of Maryland</u>		Address <u>3 weeks</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Hypertensive cardiovascular disease</u> DUE TO cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pernicious anemia</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Jan. 1, 1958, to Jan. 19, 1962</u>		(County) <u>Jan. 17, 1962</u>		(State) <u>and that death occurred at 9:40 am</u>	
21. I certify that (I) (the doctor) attended the deceased from <u>Jan. 1, 1958, to Jan. 19, 1962</u> , that (I) (we) saw the deceased alive on <u>Jan. 17, 1962</u> , and that death occurred at <u>9:40 am</u> the causes and on the date stated above.											
22a. SIGNATURE <u>S.J. Venable, Jr. M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <u>S.J. Venable, Jr. M.D.</u>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 19, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>S.J. Venable, Jr. M.D.</u>						22d. ADDRESS <u>7215 York Road, Baltimore 12, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-22-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City, town or county) <u>Pikesville, Maryland</u>		(State) <u>-</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons, Inc. 1900 Eutaw Place, 17</u>						ADDRESS <u>1900 Eutaw Place, 17</u>		25a. REC'D BY REGISTRAR <u>JAN 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>C. H. S. H. H.</u>	

00302



[Handwritten signature]

00306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>3V 01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore 17, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bent Nursing Home</u>		d. STREET ADDRESS <u>2800 Auchentoroly Terr</u>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1906</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Freeman N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.S. Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Suzie M. Spaulding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Irene Mitchell</u>		Address <u> </u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> 42221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C. V. Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7</u> days <u> </u> years
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>

21. I certify that I attended the deceased from January 12, 1962, to January 27, 1962, that I last saw the deceased alive on January 26, 1962, and that death occurred at 3:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Martin E. Strobel ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 1-27-62
M.D. Reisterstown Baltimore Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-31-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Freeman Cem</u>	22d. LOCATION (City, town, or county) <u>Freeman N.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Choy O. Wilson</u>		ADDRESS <u>1000 Bentley Ave</u>	24a. REC'D BY REGISTRAR <u>JAN 31 62</u>
24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>		DATE <u> </u>	

100000

UNITED STATES OF AMERICA

100000

M

26

100000

100000

100000

UNITED STATES OF AMERICA

100000

100000

UNITED STATES OF AMERICA

100000

UNITED STATES OF AMERICA

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
00307						00304									
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						
Baltimore			Baltimore - 12			MARYLAND			Baltimore						
7104 Sheffield Rd.															
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
Euphonia W MITCHELL						Jan. 13 19 62									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.					
F		W				Jan. 9, 1885		77 yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY			
Housewife								Scotland				Scotland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
Daniel Weir				Mary Colville				(If yes give war or dates of service)				None			
17. INFORMANT				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				Interval between onset and death			
Mrs. Alice M. Pettigrew				Carcinoma of the esophagus				7104 Sheffield Rd.				10 mos.			
19a. SIGNATURE				19b. DATE SIGNED				20a. TIME OF INJURY				20b. INJURY OCCURRED			
William F. Fritz				1/13/62				Hour a.m. p.m. 19				While at work Not While at work			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS				23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
William F. Fritz, M.D.				2 W. University parkway, Balto-18, Md.				Removal				Jan. 16 1962			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				25c. NAME OF CEMETERY OR CREMATORY			
Wm. Cook-Towson, Inc.				DATE JAN 16 '62				Charles E. Hanna				Geo. Washington Mem Park Phila. Pal			
1050 York Rd.															

VR A15 (4)
15M 9/60

00000

00000

①

Statement of the Corporation

Balance Sheet as at 31st December 1910

Assets

Fixed Assets	£ 100,000
Current Assets	£ 50,000
Total Assets	£ 150,000

Liabilities

Capital	£ 100,000
Reserves	£ 50,000
Total Liabilities	£ 150,000

Arthur S. Kraus

VS. A15ME
5M 7/59

60308 MEDICAL EXAMINER - CIVIL DEPT. OF HEALTH



RECEIVED 11-10-1918
CIVIL DEPT. OF HEALTH
RECEIVED 11-10-1918
CIVIL DEPT. OF HEALTH

1. **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

90

I

0

1

1
00309
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00306

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay			c. LENGTH OF STAY IN 1b 11 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Relay Hill Hospital				d. STREET ADDRESS 612 Pratt Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John First		Middle Morris		Last Morris		4. DATE OF DEATH Month Jan. Day 29 Year 1962	
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 2, 1895	
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 10 Days 27		11. IF UNDER 24 HRS. Hours — Min. —		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME HARRY MORRIS DECEASED				14. MOTHER'S MAIDEN NAME Friend:			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 355-07-3683		17. INFORMANT John Benjes- Anchor Hotel- 612 Pratt St; Baltimore, 2, Md. Mul- 5-5340	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary disease DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH Hours 11 Minutes —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 29 19 62 to Jan. 29 19 62 that (I) (we) last saw the deceased alive on Jan. 29 19 62 , and that death occurred at 3 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Lewis P. Gundry				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.				22d. ADDRESS Relay 27, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-2-1962		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc. 1901 Eastern Ave.				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 31 '62	
						25b. REGISTRAR'S SIGNATURE —	

00308

M

CHILD TOWN

WILSON

1911

CERTIFICATE OF DEATH

Reg. Dist. No. 00307

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ADAMSBURG LUTHERAN HOME		d. STREET ADDRESS 268 N. Wilson St	
3. NAME OF DECEASED (Type or print) MARY LOUISA MUHLY		4. DATE OF DEATH Jan 19 1962	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 28, 1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
13. FATHER'S NAME HERMAN MUHLY		14. MOTHER'S MAIDEN NAME ELIZABETH BAUER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 6511	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Arterio Sclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (2) - Hypertension DUE TO (2) - Hypertension DUE TO (2) - Hypertension		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1955 to Jan 19 1962 that I lost saw the deceased alive on Jan 18 1962 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		DATE SIGNED 1-19-62	
PHYSICIAN'S NAME (Type) Earl L. Chambers		M.D. 4108 Liberty Hts Balto - Md	
22a. NAME OF CEMETERY OR CREMATORY Immanuel Cem		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. Seemann		24a. REC'D BY REGISTRAR DATE JAN 23 '62	
24b. REGISTRAR'S SIGNATURE Wm. S. Pinner			

100-10000

CERTIFICATE OF DEATH

01230



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00311

00308

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN lb 5 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 517 N. Collington Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Edward, Jr. NAIL		4. DATE OF DEATH 1 21 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years last birthday) 6 yrs. IF UNDER 1 YEAR Months 21 Days 19 Hours 62 Min.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Edward Nail		14. MOTHER'S MAIDEN NAME Lillian M. BLUMENSTOCK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - -		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> (b) <i>Microcephalie</i> (c) <i>Cerebral dysgenesis</i> 753-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 1, 1956</i> to <i>Jan 21, 1962</i>, that (I) (we) last saw the deceased alive on <i>Jan 21, 1962</i>, and that death occurred at <i>12:30 PM</i>, from the causes and on the date stated above.			
22a. SIGNATURE <i>Ernest I. Decko</i>		22b. DATE SIGNED 1/21/62	
22c. PHYSICIAN'S NAME (Type) ERNEST I. DECKO		22d. ADDRESS ROSEWOOD ST. TR. SCHOOL	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/24/62	23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM.	23d. LOCATION (City, town or county) (State) BALTO., MD.
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Miller - 2334 Jefferson St.</i>		25a. REC'D BY REGISTRAR DATE JAN 24 1962	
ADDRESS		25b. REGISTRAR'S SIGNATURE	

11500



General Chapman
Vice-President
The Chapman

Wm. H. Chapman

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00312

00309

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2515 Lodge Forest Drive				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest d. STREET ADDRESS 2515 Lodge Forest Dr.				
3. NAME OF DECEASED (Type or print) ANNA E. NANTZ.		4. DATE OF DEATH Month Day Year January 24, 19 62.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1905		9. AGE (In years last birthday) 56 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.				
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William H. Rice					
14. MOTHER'S MAIDEN NAME Florence C. Vollerdt.			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					
16. SOCIAL SECURITY NO. 216-20-9114			17. INFORMANT Address Thomas W. Nantz, Sr. Same.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table style="width: 100%;"> <tr> <td colspan="2" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Carcinoma of uterus DUE TO Internal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 1 hour </td> <td style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH 3 years </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Carcinoma of uterus DUE TO Internal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 1 hour		INTERVAL BETWEEN ONSET AND DEATH 3 years
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X Carcinoma of uterus DUE TO Internal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 1 hour		INTERVAL BETWEEN ONSET AND DEATH 3 years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 10, 19 62 to Jan 24, 19 62 that (I) (we) last saw the deceased alive on Jan 23, 19 62 and that death occurred at 2:45 A.M. from the causes and on the date stated above.								
22a. SIGNATURE John V. Conway		22b. DATE SIGNED M.D.		22c. PHYSICIAN'S NAME (Type) JOHN V. CONWAY				
22d. ADDRESS D ST. SPARROWS POINT, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						
23b. DATE THEREOF 1-27-62.		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) 7225 Eastern Blvd. Ba. Co., Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Juler.		ADDRESS 6224 Eastern Ave. Balto., Md.		25a. REC'D BY REGISTRAR DATE JAN 29 '62				
25b. REGISTRAR'S SIGNATURE Arthur P. Francis								

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00332

1941

Lodge Forest

2111 Lodge Forest Drive

W.A.

Female White

Lodge Forest

William F. also

No

2111-20-1111

Thomas W. Hanks, Sr. Home.

Thomas G. Yelkovic

A. Home.

W.A. Home.

April 21, 1942

Lansbury

2111 Lodge Forest Dr.

Lodge Forest

Id.

1941

*Germania of the
Federal Republic*

1941

John V. Gurney
Jan 1 - 1941

Jan 10 - 1941
Jan 24 - 1941

1-25-41. Oak Lawn Cemetery

1222 Eastern Blvd.

1222 Eastern Blvd.

1222 Eastern Blvd.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00313

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00310

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turner Station</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>206 Avondale Road</u>				d. STREET ADDRESS <u>206 Avondale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Newton</u> Last <u>Newton</u>				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1924</u>	9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Ship Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Red Springs, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Newton</u>				14. MOTHER'S MAIDEN NAME <u>Barbara McGulley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>219-12-8463</u>		17. INFORMANT <u>Lenora C. Newton - 206 Avondale Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-13-62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-16-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Madison Ave., Balto., Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 16 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00314

00311

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural RANDALLSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - RANDALLSTOWN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holbrook, Liberty Rd.</u>		d. STREET ADDRESS <u>Holbrook Liberty Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter HAVILAND O'Dell</u>		4. DATE OF DEATH <u>JAN. 16, 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vault Mfg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vaults</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard O'Dell</u>		14. MOTHER'S MAIDEN NAME <u>Emily HAVILAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Vincent Carey - Baltimore, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerosis</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>1/16/62</u> , 1962, that (I) (we) last saw the deceased alive on <u>1/16/62</u> , 1962, and that death occurred <u>100 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wm. E. Martin</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		22d. ADDRESS <u>Randallstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-19-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>WARDS Chapel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore County - Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Wright</u> ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 22 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraw</u>		25c. DATE SIGNED	

11000

CENTRAL BANK OF CANADA

11000

M



TO HOSPITAL. The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00315

Item 23b, Film G305 1/25/62 iwk

00312

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 22 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston d. STREET ADDRESS 12 X 2		
3. NAME OF DECEASED (Type or print) WILLIAM K. OSBORNE			4. DATE OF DEATH Month January Day 18 Year 19 62		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH November 18, 1891		9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Grayson Co., Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Josh Osborne			
14. MOTHER'S MAIDEN NAME Nancy Farmer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			
16. SOCIAL SECURITY NO. 215-12-0509		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASIS DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. 151X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Emphysema of lungs. 2. Arteriosclerosis, generalized.					
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 27, 1961 to January 18, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 18, 1962 , and that death occurred at 4:50 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Joseph M. Miller M.D.					
22b. DATE SIGNED 1/18/62					
22c. PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D. Chief, Surgical Service					
22d. ADDRESS VAH, BALTO 18 MD FT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
23b. DATE THEREOF 1/20/1962					
23c. NAME OF CEMETERY OR CREMATORY Memorial Gardens Cemetery					
23d. LOCATION (City, town or county) (State) Bel Air, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz ADDRESS Kurtz & Son Funeral Home, Jarrettsville, Md.					
25a. REC'D BY REGISTRAR JAN 24 '62					
25b. REGISTRAR'S SIGNATURE Clifton S. Thomas					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00313

00316

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa, Route 3 Box 252 12 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Annetta Middle S. Last Pearce		4. DATE OF DEATH Month Jan. Day 5 Year 19 62	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Separated WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 13, 1889
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Frederick Wetzel		14. MOTHER'S MAIDEN NAME Louisa Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-20-0643	
17. INFORMANT Harry W. Pearce		Address Joppa Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESP FAILURE 423.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC C.V. DISEASE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 15 min. MANY YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 6, 1959 , to DEC 11 DEC 1961 , that I last saw the deceased alive on 11 DEC 1961 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 401 Franklin Bel Air Maryland DATE SIGNED 6 JAN 62 ACTUAL SIGNATURE H. P. Sidwell M.D. 401 Franklin Bel Air Maryland PHYSICIAN'S NAME (Type) Harvey P. Sidwell 401 Franklin Bel Air Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 8, 1961	22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial	22d. LOCATION (City, town, or county) (State) Abingdon Harford Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son Howard K. McComas		24a. REC'D BY REGISTRAR DATE JAN 9 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Kassis			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6

. 11. 1.

5

1

1 2

250-3 241

215-111

٦

TO HOSPITAL CLERK: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville 28</u>		c. LENGTH OF STAY IN 1b <u>8 yrs. 7 mos. 24 days</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 18</u>		d. STREET ADDRESS <u>2818 N. Calvert Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Kathleen M. Penney</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1882</u>		9. AGE (In years last birthday) <u>79</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u> Hours <u>4</u> Min. <u>4</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>62</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Angus R. Grant</u>		14. MOTHER'S MAIDEN NAME <u>Emily McCray</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic gangrene right leg</u> 45 D.O. } DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>5/13/13</u>		20g. (County) <u>1/6/62</u>		20h. (State) <u>1-7-62</u>		21. I certify that (I) (this hospital) attended the deceased from <u>5/13/13</u> 19 <u>13</u> to <u>1/6/62</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6, 1962</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Jose R. Arizaga</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>		22b. DATE SIGNED <u>1-7-62</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSP.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-10-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>		23d. LOCATION (City, town or county) <u>Taylor Avenue, Balto. Co</u>		23e. (State) <u>BALTO.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. ok, Inc., 1217 St. Paul Street Zone 2</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					



Mr. C. K. Lee, 1117 St. Paul Street, Room 2
April 2, 1952

General - 1-17-52 International Laundry Co.,
Taylor Avenue, Dallas, Texas

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,

W. A. Rorer

Special Agent in Charge

Federal Bureau of Investigation

U. S. Department of Justice

Washington, D. C.

Enclosure

Very truly yours,

W. A. Rorer

Special Agent in Charge

Federal Bureau of Investigation

U. S. Department of Justice

Washington, D. C.

Enclosure

Very truly yours,

W. A. Rorer

Special Agent in Charge

Federal Bureau of Investigation

U. S. Department of Justice

Washington, D. C.

Page 4
To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be signed by the attending physician and completely filled in by the funeral director. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1
00318 item 2 Film G307 2/13/62 iwk
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 00315

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON Baltimore 28, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ludowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 1709 Frederick Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDGAR L. PERRY		4. DATE OF DEATH Month Day Year 1 10 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restauranteur		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elisabeth City N.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas C. PERRY		14. MOTHER'S MAIDEN NAME Dora N. Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 216-05-4643	
17. INFORMANT Address Mr. Edgar L. Perry Jr. 505 Radnor Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OBSTRUCTIVE PULMONARY EMPHYSEMA 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 9 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-4 , 19 61 , to 1-10 , 19 62 , that I last saw the deceased alive on 1-10 , 19 62 , and that death occurred at 5:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED William B. Fress M.D.			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/12/62	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR JAN 11 '62	
24b. REGISTRAR'S SIGNATURE William B. Fress			

TO HOSPITAL CLERK: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1
M
X
I
0

00319

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00316

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Arm c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box. 62, Glen Arm, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Arm d. STREET ADDRESS Box 62 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Yellott Piper		4. DATE OF DEATH Month January Day 6 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1892	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired Carp.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Augustus Piper		14. MOTHER'S MAIDEN NAME Mamie Monroe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 214-12-0446	
17. INFORMANT Mrs. Thelma Piper		Address Glen Arm, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Generalized Atherosclerosis DUE TO Cardio Renal Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH Sudden 10 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 8, 1962 to Jan 6, 1962 that (I) <input checked="" type="checkbox"/> saw the deceased alive on 1/3, 1962 and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles F. O'Donnell M.D. 22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell		22b. DATE SIGNED JAN 9 1962 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Baltimore County, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 9, 1962	
23c. NAME OF CEMETERY OR CREMATORY Waugh Chapel Cemetery		23d. LOCATION (City, town or county) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co ADDRESS 4905 York Rd. Balt. 12, Md.		25a. REC'D BY REGISTRAR JAN 9 1962 25b. REGISTRAR'S SIGNATURE Robert S. Thomas	



00316

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

00320

CERTIFICATE OF DEATH

Reg. Dist. No. 00317

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1335 DEANWOOD Rd.</u>				d. STREET ADDRESS <u>1335 DEANWOOD Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Stephen</u> First <u>Mace</u> Middle <u>Plowman</u> Last				4. DATE OF DEATH <u>Jan.</u> Month <u>27</u> Day <u>1962</u> Year			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-1896</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STEPHEN PLOWMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANN SAMSEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>ANN JOHNSON</u>		INFORMANT <u>SAME</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>204.0</u> IMMEDIATE CAUSE (a) <u>Chronic lymphatic leukemia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardio-vascular disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>Jan. 27, 1962</u> that I last saw the deceased alive on <u>Dec. 1961</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R Donald Jandorf</u> M.D.				ADDRESS (Street, city or town, state) <u>6077 Harford Rd, Balto. 14, Md</u>		DATE SIGNED <u>1-27-62</u>	
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/31/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 HARFORD Rd.</u>		24a. REC'D BY REGISTRAR <u>JAN 31 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

Page 4
The law requires that the death certificate be executed within 72 hours after death.
The physician, funeral director, or attending physician.
After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

00380

1900

Blank form with horizontal lines for text entry.



Page 4
The low requires that the death certificate be executed within 24 hours after death.
TO HOSE OR TO FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00321

00318

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 44 Yrs. 7Mos.		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville		77X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION THE SHEPPARD AND ENOCH PRATT HOSPITAL		d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Eugenia Maxwell Poe		4. DATE OF DEATH Month Day Year January 11 1962		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1880	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Francis Winslow Poe		14. MOTHER'S MAIDEN NAME Harriet A. Maxwell		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		
17. INFORMANT Hospital Records		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cerebral Hemorrhage DUE TO (c) Senility				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 wks 2 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia - Paranoid Type				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1930 to Jan 11, 1962 that (I) (we) last saw the deceased alive on Jan 10, 1962 and that death occurred at 9:35 PM from the causes and on the date stated above.				
22a. SIGNATURE W. W. Elgin		22b. DATE SIGNED January 11, 1962		
22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		22d. ADDRESS Towson 4, Maryland The Sheppard and Enoch Pratt Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-11-62		
23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION (City, town, or county) (State) Greenville, South Carolina		
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Pickens Sons Balto 17 Md.		25a. REC'D BY REGISTRAR DATE JAN 12 '62		
25b. REGISTRAR'S SIGNATURE Wm S. Thomas				

CERTIFICATE OF DEATH

1932

199

1

1932

1932

1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00319

00322

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Powers Av		d. STREET ADDRESS Powers Av	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SYLVESTER Middle POLLOCK Last POLLOCK		4. DATE OF DEATH Month Jan. Day 1 Year 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1895
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Pollock		14. MOTHER'S MAIDEN NAME Annie Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-01-3995	
17. INFORMANT Mrs. Bessie Pollock		Address Oella, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Valvular Disease 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Valvular Lesions DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1961 , to Jan. 1, 1962 , that I last saw the deceased alive on Jan. 1, 1962 , and that death occurred at 9:25 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Pollock		ADDRESS (Street, city or town, state) DATE SIGNED R. H. Baylis Oella, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-62	
22c. NAME OF CEMETERY OR CREMATORY Western Star Cem		22d. LOCATION (City, town, or county) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Pollock		ADDRESS 578 W. ...	
24a. REC'D BY REGISTRAR JAN 4 '62		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH JAN 15 1895		PLACE OF BIRTH BALTIMORE, MD.	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED		DATE OF MARRIAGE JAN 15 1915	
DATE OF DEATH JAN 15 1925		PLACE OF DEATH BALTIMORE, MD.		CAUSE OF DEATH HEART DISEASE	
DISEASE OR INJURY HEART DISEASE		PERIOD OF ILLNESS 2 WEEKS		TREATMENT HOSPITAL	
SIGNATURE OF DECEASED JAMES H. HARRIS		SIGNATURE OF WITNESS JAMES H. HARRIS		SIGNATURE OF PHYSICIAN JAMES H. HARRIS	
DATE OF SIGNATURE JAN 15 1925		DATE OF SIGNATURE JAN 15 1925		DATE OF SIGNATURE JAN 15 1925	
PLACE OF SIGNATURE BALTIMORE, MD.		PLACE OF SIGNATURE BALTIMORE, MD.		PLACE OF SIGNATURE BALTIMORE, MD.	
NAME OF DECEASED JAMES H. HARRIS		DATE OF BIRTH JAN 15 1895		PLACE OF BIRTH BALTIMORE, MD.	
SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		MARRIAGE MARRIED		DATE OF MARRIAGE JAN 15 1915	
DATE OF DEATH JAN 15 1925		PLACE OF DEATH BALTIMORE, MD.		CAUSE OF DEATH HEART DISEASE	
DISEASE OR INJURY HEART DISEASE		PERIOD OF ILLNESS 2 WEEKS		TREATMENT HOSPITAL	
SIGNATURE OF DECEASED JAMES H. HARRIS		SIGNATURE OF WITNESS JAMES H. HARRIS		SIGNATURE OF PHYSICIAN JAMES H. HARRIS	
DATE OF SIGNATURE JAN 15 1925		DATE OF SIGNATURE JAN 15 1925		DATE OF SIGNATURE JAN 15 1925	
PLACE OF SIGNATURE BALTIMORE, MD.		PLACE OF SIGNATURE BALTIMORE, MD.		PLACE OF SIGNATURE BALTIMORE, MD.	



RECEIVED
JAN 15 1925
BALTIMORE, MD.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00323

CERTIFICATE OF DEATH

Reg. Dist. No. 10320

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 45 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chapel Hill Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Edgar Westwood Poole		4. DATE OF DEATH Month Day Year Jan. 24, 1962.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1869
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer B. & O. R.R.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Poole		14. MOTHER'S MAIDEN NAME Mary M. Buxton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Charles I. Naylor		Address 1819 Alto Vista Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Generalized Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 13, 1934 to Jan. 24, 1962 , that I last saw the deceased alive on Jan. 21, 1962 , and that death occurred at 9:17 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4108 Liberty Hg - Balto - Md. DATE SIGNED 1-26-62 ACTUAL SIGNATURE Earl L. Chambers M.D. 4108 Liberty Hg - Balto - Md. PHYSICIAN'S NAME (Type) Earl L. Chambers 4108 Liberty Hg - Balto - Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-1962	
22c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel		22d. LOCATION (City, town, or county) (State) Claggettville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong		24a. REC'D BY REGISTRAR JAN 29 '62	
ADDRESS 3707 North Ave		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used for the purpose of recording the death. This certificate has been signed by the attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

00323

PLACE OF BIRTH Baltimore		SEX Male	
DATE OF BIRTH 1912		AGE 21	
OCCUPATION Student		CAUSE OF DEATH Pneumonia	
PLACE OF DEATH Baltimore		DATE OF DEATH 1933	
NAME OF DECEASED John J. Smith		NAME OF NEXT OF KIN John J. Smith	
ADDRESS 1234 Main St. Baltimore, Md.		SIGNATURE OF DECEASED John J. Smith	
SIGNATURE OF NEXT OF KIN John J. Smith		SIGNATURE OF PHYSICIAN Dr. J. J. Smith	
SIGNATURE OF CLERK J. J. Smith		SIGNATURE OF REGISTRAR J. J. Smith	

00324

CERTIFICATE OF DEATH

00321

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bent Nursing Home</u>		d. STREET ADDRESS <u>2824 Prestman St</u>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Prater</u> Last <u>Prater</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>14</u> Year <u>1962</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>e</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-92</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sash Prater</u>		14. MOTHER'S MAIDEN NAME <u>Frances Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>214-01-8923A</u>	
17. INFORMANT <u>Alma Stone</u>		Address <u>2824 Prestman St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (terminal)</u> <u>4-22-62</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease with</u> DUE TO <u>cardiac decompensation</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 8, 1962</u> , to <u>January 14, 1962</u> , that I last saw the deceased alive on <u>January 14th, 1962</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		ADDRESS (Street, city or town, state) <u>48 Main Street</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		DATE SIGNED <u>1-15-62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-18-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calvary cm</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>26 S. Nelson</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 17 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE _____

VR A15 (4)
15M 9/60

00382

00382

(M)

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

Belgium

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

M

I

50

0

BP

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00326 CERTIFICATE OF DEATH 00323														
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b 14 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25 d. STREET ADDRESS 402 Jack Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) JOHN W. PUTSCHKY			First Middle Last		4. DATE OF DEATH January 25 19 62		Month Day Year							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 23, 1917		9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME John Putschky					14. MOTHER'S MAIDEN NAME Minnie Gast									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II					16. SOCIAL SECURITY NO. 217-09-5511					17. INFORMANT Clinical Records, VAH, BALTIMORE 18 MD. Address Fort Howard Division				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO 581.1 Conditions, if any, which gave rise to immediate cause (b) LAENNEC'S CIRRHOSIS DUE TO 581.1 (c) 581.1								INTERVAL BETWEEN ONSET AND DEATH 1 WEEK						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA Operation 1/24/62: Tracheotomy								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19 62			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan. 11 1962 to Jan. 25 1962 that (I) (we) last saw the deceased alive on Jan. 25 1962 , and that death occurred at 12:05 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Irving Freeman M.D.					22b. DATE 1/25/62									
22c. PHYSICIAN'S NAME (Type or print) IRVING FREEMAN, M.D.					22d. ADDRESS VAH, BALTIMORE 18 MD FT HOWARD DIVISION									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-27-62		23c. NAME OF CEMETERY OR CREMATORY Green Hill Cem.		23d. LOCATION (City, town or county) (State) Brooklyn Md.							
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home					ADDRESS 130 E. Fort Ave		25a. REC'D BY REGISTRAR JAN 30 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna					

VR A15 (4)
15M 9/60

(M)

00388

First Name

Last Name

Veterans Administration Hospital

John Howard

JOHN

HOWARD

Birth

October 23, 1917

Registration

Washington

Washington, D.C.

John Howard

John Howard

Yes

1911

1911-1912

1911-1912

Medical Officer

1911-1912

Operation 1911-1912: Washington

Jan. 23, 1917

Jan. 23, 1917

Chief, Medical

Service

1911-1912

CERTIFICATE OF DEATH

00327

04324

1. PLACE OF DEATH e. COUNTY		BALTO		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE		Md.		b. COUNTY											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Balto		3001-4									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Paradise Nursing Home 18 Paradise Ave				d. STREET ADDRESS		1514 Sycamore St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year							
Mary		Jane		Rabidoux				1/27/62		19											
5. SEX		F		6. COLOR OR RACE		White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
								WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		July 1, 1868		93 yrs.		Months		Days		Hours		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		None		11. BIRTHPLACE (County & State, or foreign country)		England		12. CITIZEN OF WHAT COUNTRY?		USA.							
13. FATHER'S NAME		Unknown		14. MOTHER'S MAIDEN NAME		Unknown															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give year or dates of service)		16. SOCIAL SECURITY NO.				17. INFORMANT		Address		Wm. T Upton Lyndale Rd. Lake Shore Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		443X		DUE TO		Hypertensive Cardio Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		Pneumonia															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		Chronic Urinary tract infection		Dracutis Ulcers		Hypertension		19. WAS AUTOPSY PERFORMED?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
								Hour e.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
21. I certify that (I) (this hospital) attended the deceased from 1/3/62 to 1/27/62, that (I) (we) last saw the deceased alive on 1/28/62, and that death occurred at 11 PM, from the causes and on the date stated above																					
22a. SIGNATURE		W. E. McGrothland		M.D.		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22b. DATE SIGNED		1/29/62									
22c. PHYSICIAN'S NAME (Type)		W. E. McGrothland				22d. ADDRESS		1303 Frederick Rd													
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		1.30. 62		23c. NAME OF CEMETERY OR CREMATORY		Glen Haven		23d. LOCATION (City, town or county)		A.A. CO Md.							
24 FUNERAL DIRECTOR'S SIGNATURE		McGully		ADDRESS		130 E Fort Ave		Balto 30 Md.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
												DATE JAN 30 '62		C. S. Thomas							

TO HOSPITAL CORPSE. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

VR A1S (4)
ISM 9/60

1968

STATE OF TEXAS

1968



100-100000

100-100000



100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

CERTIFICATE OF DEATH

Reg. Dist. No.

00326

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>LTC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3000 E. Lindwood Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>M</u> Last <u>RASSA</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 4 1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John F. Bloberger</u>		14. MOTHER'S MAIDEN NAME <u>Meta Prestpopp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>August Rassa</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 420.0 DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>2 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1 - 1952</u> to <u>Jan 29 1962</u> , that I last saw the deceased alive on <u>Jan 21 1962</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George Sawyer</u> M.D.		ADDRESS (Street, city or town, state) <u>4808 Harford Rd - Balto. 14. Md.</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE SAWYER, M.D.</u>		DATE SIGNED <u>1/31/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 2 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHAS F. EVANS & Son</u>		ADDRESS <u>8802 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>FEB 5 '62</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00330
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyde</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hyde</u>	
c. LENGTH OF STAY IN lb <u>3 months</u>		d. STREET ADDRESS <u>Hyde</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Archie Phlegar Ratcliffe</u>		4. DATE OF DEATH Month Day Year <u>Jan. 2 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1887</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dephas Ratcliffe</u>		14. MOTHER'S MAIDEN NAME <u>Hennette Hughes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>223-10-9362</u>	
17. INFORMANT <u>Mrs. Mervin Williams</u>		Address <u>Hyde Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Multiple Myeloma</u> 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yr. +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1961</u> to <u>Jan. 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 1, 1961</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William A. Tjorn</u> M.D.		22b. DATE SIGNED <u>1-2-62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Kingsville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/5/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Highland Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Dublin Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles C. Hunt</u>		25a. REC'D BY REGISTRAR <u>JAN 4 '62</u>	
ADDRESS <u>Garrettsville Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Farris</u>	

0530



2

DEATH CERTIFICATE EXAMINER: This certificate should be executed within 24 hours after death. If a delay in filing, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

X

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00331

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

011328

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4		d. STREET ADDRESS 1406 Maywood Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 319 Broadway Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edward		First Fallon		Middle Ray		Last Jan.	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-25-15	
9. AGE (In years last birthday) 46		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY American Oil Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Ray		14. MOTHER'S MAIDEN NAME Doris Fallon					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes WWII		16. SOCIAL SECURITY NO. 217-05-8251		17. INFORMANT Mrs. Mary C. Ray, 1406 Maywood Ave., Ruxton 4, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ACTUAL SIGNATURE D. D. Caples		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-29-62			
EXAMINER'S NAME (Type) D. D. Caples, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-62		22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		22d. LOCATION (City, town, or country) (State) Cockeysville, Md.	
23. FUNERAL DIRECTOR Brooks Funeral Service, Inc., Towson 4, Md.		ADDRESS 6 Hanover Rd., Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 31 '62		24b. REGISTRAR'S SIGNATURE Calvin S. Harris	

VS. A15ME
5M 9/60

NO. 100
100-100

M

Bellevue

Bellevue

317 Broadway, N.Y.

1947

1947

1947

Truck Driver

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

1947

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00332

00329

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5902 CHARNWOOD RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BAKTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u> d. STREET ADDRESS <u>15902 CHARNWOOD RD.</u>			
3. NAME OF DECEASED (Type or print) <u>ROSALIE REDDEN</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>9</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 14, 1870</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			
12. CITIZEN OF WHAT COUNTRY? <u> </u>			13. FATHER'S NAME <u>BEACH BOARD</u>				
14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				
16. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>W. Keith Redden - 5902 Charnwood Rd.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 492X DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis Generalized</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5</u> , 19 <u>62</u> to <u>Jan 9</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>Jan 8</u> , 19 <u>62</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Nelson McKay</u> M.D.				22b. DATE SIGNED <u>Jan 12, 1962</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-12-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>			
23d. LOCATION (City, town or county) (State) <u>Woodlawn, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Lowley Caraway L.F.H. - Catonsville, Md.</u>					
25a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>					

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED

25893

M

T



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12
M
90
I

00333

00330

0

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Holbrook		c. LENGTH OF STAY IN lb 4 Mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Convalescent Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7	
3. NAME OF DECEASED (Type or print) Mrs. Lydia Reichlin		d. STREET ADDRESS 2533 Cedar Drive	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 6, 1872	
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Switzerland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Heinrich Rebsamen		14. MOTHER'S MAIDEN NAME Unknown Marie Gonzenbach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Werner Kloetzli, Baltimore 7, Maryland		Address 2533 Cedar Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Arterio Sclerotic Cerebro Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) 7 yrs DUE TO (c) 3 mo		INTERVAL BETWEEN ONSET AND DEATH 3 mo 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Thrombophlebitis of the right leg			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 26, 1962 to Jan 13, 1963 ; that (I) (we) last saw the deceased alive on Jan 12, 1962 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Albert Schochat		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Albert Schochat		22d. ADDRESS 4111 Liberty Heights Ave., Balto. 7, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town or county) (State) Randallstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Byers		25a. REC'D BY REGISTRAR DATE JAN 17 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume		25c. REGISTRAR'S SIGNATURE	

00333

STATE OF TEXAS

1933

IN SENATE,
January 15, 1933.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1932.
BY
J. B. HARRIS,
COMMISSIONER.
HARRIS, J. B.
1933
1932
1931
1930
1929
1928
1927
1926
1925
1924
1923
1922
1921
1920
1919
1918
1917
1916
1915
1914
1913
1912
1911
1910
1909
1908
1907
1906
1905
1904
1903
1902
1901
1900
1899
1898
1897
1896
1895
1894
1893
1892
1891
1890
1889
1888
1887
1886
1885
1884
1883
1882
1881
1880
1879
1878
1877
1876
1875
1874
1873
1872
1871
1870
1869
1868
1867
1866
1865
1864
1863
1862
1861
1860
1859
1858
1857
1856
1855
1854
1853
1852
1851
1850
1849
1848
1847
1846
1845
1844
1843
1842
1841
1840
1839
1838
1837
1836
1835
1834
1833
1832
1831
1830
1829
1828
1827
1826
1825
1824
1823
1822
1821
1820
1819
1818
1817
1816
1815
1814
1813
1812
1811
1810
1809
1808
1807
1806
1805
1804
1803
1802
1801
1800
1799
1798
1797
1796
1795
1794
1793
1792
1791
1790
1789
1788
1787
1786
1785
1784
1783
1782
1781
1780
1779
1778
1777
1776
1775
1774
1773
1772
1771
1770
1769
1768
1767
1766
1765
1764
1763
1762
1761
1760
1759
1758
1757
1756
1755
1754
1753
1752
1751
1750
1749
1748
1747
1746
1745
1744
1743
1742
1741
1740
1739
1738
1737
1736
1735
1734
1733
1732
1731
1730
1729
1728
1727
1726
1725
1724
1723
1722
1721
1720
1719
1718
1717
1716
1715
1714
1713
1712
1711
1710
1709
1708
1707
1706
1705
1704
1703
1702
1701
1700
1699
1698
1697
1696
1695
1694
1693
1692
1691
1690
1689
1688
1687
1686
1685
1684
1683
1682
1681
1680
1679
1678
1677
1676
1675
1674
1673
1672
1671
1670
1669
1668
1667
1666
1665
1664
1663
1662
1661
1660
1659
1658
1657
1656
1655
1654
1653
1652
1651
1650
1649
1648
1647
1646
1645
1644
1643
1642
1641
1640
1639
1638
1637
1636
1635
1634
1633
1632
1631
1630
1629
1628
1627
1626
1625
1624
1623
1622
1621
1620
1619
1618
1617
1616
1615
1614
1613
1612
1611
1610
1609
1608
1607
1606
1605
1604
1603
1602
1601
1600
1599
1598
1597
1596
1595
1594
1593
1592
1591
1590
1589
1588
1587
1586
1585
1584
1583
1582
1581
1580
1579
1578
1577
1576
1575
1574
1573
1572
1571
1570
1569
1568
1567
1566
1565
1564
1563
1562
1561
1560
1559
1558
1557
1556
1555
1554
1553
1552
1551
1550
1549
1548
1547
1546
1545
1544
1543
1542
1541
1540
1539
1538
1537
1536
1535
1534
1533
1532
1531
1530
1529
1528
1527
1526
1525
1524
1523
1522
1521
1520
1519
1518
1517
1516
1515
1514
1513
1512
1511
1510
1509
1508
1507
1506
1505
1504
1503
1502
1501
1500
1499
1498
1497
1496
1495
1494
1493
1492
1491
1490
1489
1488
1487
1486
1485
1484
1483
1482
1481
1480
1479
1478
1477
1476
1475
1474
1473
1472
1471
1470
1469
1468
1467
1466
1465
1464
1463
1462
1461
1460
1459
1458
1457
1456
1455
1454
1453
1452
1451
1450
1449
1448
1447
1446
1445
1444
1443
1442
1441
1440
1439
1438
1437
1436
1435
1434
1433
1432
1431
1430
1429
1428
1427
1426
1425
1424
1423
1422
1421
1420
1419
1418
1417
1416
1415
1414
1413
1412
1411
1410
1409
1408
1407
1406
1405
1404
1403
1402
1401
1400
1399
1398
1397
1396
1395
1394
1393
1392
1391
1390
1389
1388
1387
1386
1385
1384
1383
1382
1381
1380
1379
1378
1377
1376
1375
1374
1373
1372
1371
1370
1369
1368
1367
1366
1365
1364
1363
1362
1361
1360
1359
1358
1357
1356
1355
1354
1353
1352
1351
1350
1349
1348
1347
1346
1345
1344
1343
1342
1341
1340
1339
1338
1337
1336
1335
1334
1333
1332
1331
1330
1329
1328
1327
1326
1325
1324
1323
1322
1321
1320
1319
1318
1317
1316
1315
1314
1313
1312
1311
1310
1309
1308
1307
1306
1305
1304
1303
1302
1301
1300
1299
1298
1297
1296
1295
1294
1293
1292
1291
1290
1289
1288
1287
1286
1285
1284
1283
1282
1281
1280
1279
1278
1277
1276
1275
1274
1273
1272
1271
1270
1269
1268
1267
1266
1265
1264
1263
1262
1261
1260
1259
1258
1257
1256
1255
1254
1253
1252
1251
1250
1249
1248
1247
1246
1245
1244
1243
1242
1241
1240
1239
1238
1237
1236
1235
1234
1233
1232
1231
1230
1229
1228
1227
1226
1225
1224
1223
1222
1221
1220
1219
1218
1217
1216
1215
1214
1213
1212
1211
1210
1209
1208
1207
1206
1205
1204
1203
1202
1201
1200
1199
1198
1197
1196
1195
1194
1193
1192
1191
1190
1189
1188
1187
1186
1185
1184
1183
1182
1181
1180
1179
1178
1177
1176
1175
1174
1173
1172
1171
1170
1169
1168
1167
1166
1165
1164
1163
1162
1161
1160
1159
1158
1157
1156
1155
1154
1153
1152
1151
1150
1149
1148
1147
1146
1145
1144
1143
1142
1141
1140
1139
1138
1137
1136
1135
1134
1133
1132
1131
1130
1129
1128
1127
1126
1125
1124
1123
1122
1121
1120
1119
1118
1117
1116
1115
1114
1113
1112
1111
1110
1109
1108
1107
1106
1105
1104
1103
1102
1101
1100
1099
1098
1097
1096
1095
1094
1093
1092
1091
1090
1089
1088
1087
1086
1085
1084
1083
1082
1081
1080
1079
1078
1077
1076
1075
1074
1073
1072
1071
1070
1069
1068
1067
1066
1065
1064
1063
1062
1061
1060
1059
1058
1057
1056
1055
1054
1053
1052
1051
1050
1049
1048
1047
1046
1045
1044
1043
1042
1041
1040
1039
1038
1037
1036
1035
1034
1033
1032
1031
1030
1029
1028
1027
1026
1025
1024
1023
1022
1021
1020
1019
1018
1017
1016
1015
1014
1013
1012
1011
1010
1009
1008
1007
1006
1005
1004
1003
1002
1001
1000
999
998
997
996
995
994
993
992
991
990
989
988
987
986
985
984
983
982
981
980
979
978
977
976
975
974
973
972
971
970
969
968
967
966
965
964
963
962
961
960
959
958
957
956
955
954
953
952
951
950
949
948
947
946
945
944
943
942
941
940
939
938
937
936
935
934
933
932
931
930
929
928
927
926
925
924
923
922
921
920
919
918
917
916
915
914
913
912
911
910
909
908
907
906
905
904
903
902
901
900
899
898
897
896
895
894
893
892
891
890
889
888
887
886
885
884
883
882
881
880
879
878
877
876
875
874
873
872
871
870
869
868
867
866
865
864
863
862
861
860
859
858
857
856
855
854
853
852
851
850
849
848
847
846
845
844
843
842
841
840
839
838
837
836
835
834
833
832
831
830
829
828
827
826
825
824
823
822
821
820
819
818
817
816
815
814
813
812
811
810
809
808
807
806
805
804
803
802
801
800
799
798
797
796
795
794
793
792
791
790
789
788
787
786
785
784
783
782
781
780
779
778
777
776
775
774
773
772
771
770
769
768
767
766
765
764
763
762
761
760
759
758
757
756
755
754
753
752
751
750
749
748
747
746
745
744
743
742
741
740
739
738
737
736
735
734
733
732
731
730
729
728
727
726
725
724
723
722
721
720
719
718
717
716
715
714
713
712
711
710
709
708
707
706
705
704
703
702
701
700
699
698
697
696
695
694
693
692
691
690
689
688
687
686
685
684
683
682
681
680
679
678
677
676
675
674
673
672
671
670
669
668
667
666
665
664
663
662
661
660
659
658
657
656
655
654
653
652
651
650
649
648
647
646
645
644
643
642
641
640
639
638
637
636
635
634
633
632
631
630
629
628
627
626
625
624
623
622
621
620
619
618
617
616
615
614
613
612
611
610
609
608
607
606
605
604
603
602
601
600
599
598
597
596
595
594
593
592
591
590
589
588
587
586
585
584
583
582
581
580
579
578
577
576
575
574
573
572
571
570
569
568
567
566
565
564
563
562
561
560
559
558
557
556
555
554
553
552
551
550
549
548
547
546
545
544
543
542
541
540
539
538
537
536
535
534
533
532
531
530
529
528
527
526
525
524
523
522
521
520
519
518
517
516
515
514
513
512
511
510
509
508
507
506
505
504
503
502
501
500
499
498
497
496
495
494
493
492
491
490
489
488
487
486
485
484
483
482
481
480
479
478
477
476
475
474
473
472
471
470
469
468
467
466
465
464
463
462
461
460
459
458
457
456
455
454
453
452
451
450
449
448
447
446
445
444
443
442
441
440
439
438
437
436
435
434
433
432
431
430
429
428
427
426
425
424
423
422
421
420
419
418
417
416
415
414
413
412
411
410
409
408
407
406
405
404
403
402
401
400
399
398
397
396
395
394
393
392
391
390
389
388
387
386
385
384
383
382
381
380
379
378
377
376
375
374
373
372
371
370
369
368
367
366
365
364
363
362
361
360
359
358
357
356
355
354
353
352
351
350
349
348
347
346
345
344
343
342
341
340
339
338
337
336
335
334
333
332
331
330
329
328
327
326
325
324
323
322
321
320
319
318
317
316
315
314
313
312
311
310
309
308
307
306
305
304
303
302
301
300
299
298
297
296
295
294
293
292
291
290
289
288
287
286
285
284
283
282
281
280
279
278
277
276
275
274
273
272
271
270
269
268
267
266
265
264
263
262
261
260
259
258
257
256
255
254
253
252
251
250
249
248
247
246
245
244
243
242
241
240
239
238
237
236
235
234
233
232
231
230
229
228
227
226
225
224
223
222
221
220
219
218
217
216
215
214
213
212
211
210
209
208
207
206
205
204
203
202
201
200
199
198
197
196
195
194
193
192
191
190
189
188
187
186
185
184
183
182
181
180
179
178
177
176
175
174
173
172
171
170
169
168
167
166
165
164
163
162
161
160
159
158
157
156
155
154
153
152
151
150
149
148
147
146
145
144
143
142
141
140
139
138
137
136
135
134
133
132
131
130
129
128
127
126
125
124
123
122
121
120
119
118
117
116
115
114
113
112
111
110
109
108
107
106
105
104
103
102
101
100
99
98
97
96
95
94
93
92
91
90
89
88
87
86
85
84
83
82
81
80
79
78
77
76
75
74
73
72
71
70
69
68
67
66
65
64
63
62
61
60
59
58
57
56
55
54
53
52
51
50
49
48
47
46
45
44
43
42
41
40
39
38
37
36
35
34
33
32
31
30
29
28
27
26
25
24
23
22
21
20
19
18
17
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00334. MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 5, 6, & 7 Film 0306 1/31/62 ink											
00331											
1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Balto.</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wally Neck Rd. Balto. 21</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>1</i>		4. DATE OF DEATH Month <i>Jan.</i> Day <i>24</i> Year <i>1962</i>					
3. NAME OF DECEASED (Type or print) <i>Philip John Remlein</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 1894</i>		9. AGE (In years last birthday) <i>67</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nanny Man</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>					
13. FATHER'S NAME <i>John Remlein</i>		14. MOTHER'S MAIDEN NAME <i>Frederika Youngkon</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give number or dates of service)		17. INFORMANT <i>Sister (810 Parkles Terrace)</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>A-S-C-V- Disease</i>											
4-22-1 DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>M.B. Davis</i>											
EXAMINER'S NAME (Type) <i>M.B. DAVIS MD</i>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county)											
DATE SIGNED <i>1/25/62</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>											
22b. DATE THEREOF <i>1-25-62</i>											
22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>											
22d. LOCATION (City, town, or country) (State) <i>Balto. Md.</i>											
23. FUNERAL DIRECTOR <i>John G. Connolly</i>											
Address <i>418 Eastern Blvd.</i>											
24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>											
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>											
DATE <i>JAN 26 '62</i>											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be marked "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
00335 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00332

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Norwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6919 DeLVALLE PLACE</u>		1. STREET ADDRESS <u>6919 DeLVALLE PLACE</u>	
3. NAME OF DECEASED (Type or print) <u>EDITH</u> First Middle Last		4. DATE OF DEATH <u>JANUARY 23 1962</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 23, 1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Providence, Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS IRMA MALONE</u> Address <u>6019 DeLVALLE PLACE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C-V-DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-27-1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LILLY & ZILOR INC 1901 EASTON AVENUE</u>		24a. REC'D BY REGISTRAR <u>DATE JAN 26 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u>	

FOR STATE
HEALTH OFF.



THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE STATE HEALTH OFFICER, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER. IT IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER.



STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE STATE HEALTH OFFICER
ALBANY, N. Y.

00328 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
18

Form with multiple sections for medical examination and death certification, including fields for patient information, cause of death, and examiner details.

1. NAME OF DECEASED: _____

2. SEX: ☐ Male ☐ Female

3. AGE: _____

4. OCCUPATION: _____

5. PLACE OF BIRTH: _____

6. DATE OF DEATH: _____

7. TIME OF DEATH: _____

8. CAUSE OF DEATH: _____

9. MANNER OF DEATH: _____

10. SIGNATURE OF EXAMINER: _____

11. DATE: _____

12. PLACE: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

00333

00336

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLGATE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XCOLGATE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>508 OLD NORTH POINT RD</u>		d. STREET ADDRESS <u>508 OLD NORTH POINT ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>RIPPEL</u>		4. DATE OF DEATH Month Day Year <u>JAN</u> <u>5</u> <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FILTERER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YEAST</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>RIPPEL</u>	
14. MOTHER'S MAIDEN NAME <u>AMANDA</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W W 1 5/24/18-6/7/1925-09-68</u>	
16. SOCIAL SECURITY NO. <u>62-1925-09-68</u>		INFORMANT Address <u>MRS ANNA SMITH 6524 ST. HELENE AV</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>9/1/61</u> , 19____, to <u>1/5/62</u> , 19____, that I last saw the deceased alive on <u>1/5/62</u> , 19____, and that death occurred at <u>5:40 P. M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Max Baum</u>		ADDRESS (Street, city or town, State) <u>7422 Eastern Ave</u> DATE SIGNED <u>1/6/62</u>	
PHYSICIAN'S NAME (Type) <u>MAX BAUM</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/9/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAR LAWN CEMETERY</u>	22d. LOCATION (City, town, or county) <u>COLGATE MD</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME - DUNDALK MD.</u>		24a. REC'D BY REGISTRAR <u>JAN 10 1962</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00337

00334

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Owings Mills</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>208 Main Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Edward Roberts Jr.</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>13,</u> Year <u>19 62</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1929</u>	9. AGE (In years last birthday) <u>32 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanics at Bowling Alley</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>George E. Roberts Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Glady's Wade</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>138-22-9260</u>		17. INFORMANT Address <u>Mrs. Helen M. Roberts Owings Mills Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull (autoaccident)</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>struck utility pole & his car</u>					
20c. TIME OF INJURY Month, Day, Year <u>1:35 a.m. Jan 13 1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Reisterstown, Balto. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>D. D. Caples</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. CAPLES, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-13-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 16, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Linden, N.J.</u>	
23. FUNERAL DIRECTOR ADDRESS <u>J. F. Eline & Sons Reisterstown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 16 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

00033



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 2 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

90

I

0

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00338

00335

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHADY NOOK CONVALESCENT HOME</u>		d. STREET ADDRESS <u>5546 GWYNN OAK AVE</u>	
3. NAME OF DECEASED (Type or print) <u>CAROLINE VIRGINIA ROBERTSON</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>20.</u> Year <u>1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 16, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>PHINNUS GETZENDEANNER</u>	
14. MOTHER'S MAIDEN NAME <u>SARAH WEEKS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. HELEN GETZENDEANNER</u> <u>5546 GWYNN OAK AVE, BALTO. 7, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular disease</u> 4-22-1 Conditions, if any, which gave rise to immediate cause (b) <u>Pneumonia</u> (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 4, 1961</u> to <u>Jan 20, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 20, 1962</u> , and that death occurred at <u> </u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>D. C. MacLaughlin</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin, M.D.</u>		22d. ADDRESS <u>4508 Edmondson Village</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/23/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE, 4101 EDMONDSON AVE.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

255-101

STATE OF TEXAS

00338

M

1



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00339 CERTIFICATE OF DEATH 00336											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1804 Maxwell Ave. # 22						d. STREET ADDRESS 1804 Maxwell Ave. # 22. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FRANCES RODENBERG.						4. DATE OF DEATH January 15, 1962.					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY House Work.		11. BIRTHPLACE (County & State, or foreign country) Germany				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinand Dahms						14. MOTHER'S MAIDEN NAME Alvina ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-34-4354		17. INFORMANT Elizabeth Fritz Address Same.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420-0 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-3-62 19 62 , to 1-15-62 19 62 , that (I) (we) last saw the deceased alive on 1-12-62 19 62 , and that death occurred at 2:00 P. from the causes and on the date stated above.											
22a. SIGNATURE John Constantini M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-16-62			
22c. PHYSICIAN'S NAME (Type) JOHN CONSTANTINI						22d. ADDRESS 234 S. Conkling St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-62.		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) 7225 Eastern Blvd. Ba. Co., Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler						ADDRESS 901 S. Conkling St. Balto., Md.		25a. REC'D BY REGISTRAR JAN 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

4330

growth rate

USDA 1995

ST. JOHN'S COLLEGE

• • •

1998

• **end**

2000

— — —

• 25 •

12-21-53

1999

100-443881-100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. STREET ADDRESS 1030 Homewood Avenue	
3. NAME OF DECEASED (Type or print) First Rada Middle Blanch Last Rogers		4. DATE OF DEATH Month 1 Day 4 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/181
9. AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) W. Va		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Silas Dary		14. MOTHER'S MAIDEN NAME Dona Everett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 10 yrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far Advanced Pulmonary Tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/31, 1961 to 1/4, 1962 that (I) (we) last saw the deceased alive on 1/4, 1962 , and that death occurred at P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 1/4/62	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 5, '62	23c. NAME OF CEMETERY OR CREMATORY Warfield	23d. LOCATION (City, town, or county) (State) Warfield, W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE Emmett B. Gardner, Gaithersburg Md.		25a. REC'D BY REGISTRAR DATE JAN 8 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

00337

00340

Item 2 Film G305 1/10/62 iwk

02

1

0

002.1

By Phone : 3/1/62

Res. should actually be Montg. Co.
since they have the tbc. case.

B. City refused to accept the death
as a City resident.

The City address was from a
guest to the Asbury Home.

A copy will be sent to Montg. Co.

ITS.

3/1/62

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00338

00341

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PARKVILLE</u>		LENGTH OF STAY (in this place) <u>20 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PARKVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3310 Willoughby Road.</u>				STREET ADDRESS (If rural give location) <u>3310 Willoughby Road</u>			
3. NAME OF DECEASED (Type or Print) <u>LULA E. ROLLISON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 3 - 1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Sept 27 - 1904</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE F. MYERS</u>				14. MOTHER'S MAIDEN NAME <u>Not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			16. SOCIAL SECURITY NO. <u>215-05-9458</u>	17. INFORMANT & ADDRESS <u>Earl V. Rollison</u> <u>3310 Willoughby Rd</u> <u>14</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
33X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						<u>15 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year)			21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21i. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>Jan. 57</u> to <u>Jan. 1962</u> , that I last saw the deceased alive on <u>Dec 27, 1961</u> , and that death occurred at <u>11:30 p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Rollison</u>				M.D. <u>Brookland Rd. Balt. 14 Md.</u>		DATE SIGNED <u>1/4/62</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Jan. 6 - 1962</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
24. RECEIVED BY REGISTRAR DATE <u>JAN 5 '62</u>		REGISTRAR'S SIGNATURE <u>Rollison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Strong</u>		ADDRESS <u>3207 North Ave</u>	

CERTIFICATE OF DEATH

1934

Reg. Gen. No.

<p>NAME OF DECEASED <i>John F. Jones</i></p>		<p>DATE OF DEATH <i>May 15, 1934</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>PLACE OF BIRTH <i>Johns Hopkins</i></p>		<p>RESIDENCE <i>1234 Main St. Baltimore, Md.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i></p>	
<p>DATE OF BURIAL <i>May 17, 1934</i></p>		<p>PLACE OF BURIAL <i>St. Mary's Cemetery</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i></p>		<p>SIGNATURE OF REGISTRAR <i>John F. Jones</i></p>	

SMITH JONES

REGISTERED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
00342
M
X
I
0
1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00339

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 628 Ingleside Avenue				d. STREET ADDRESS 628 Ingleside Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Elizabeth Rumuly				4. DATE OF DEATH Month Day Year Jan. 1st., 19 62			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1943	
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurses Aid				10b. KIND OF BUSINESS OR INDUSTRY Keswick Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Elizabeth Margaret ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-40-1603		17. INFORMANT Mrs. John Schene 628 Ingleside Ave. Catonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) acute Status Asthmaticus DUE TO (c) 12 hrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17 Mon				INTERVAL BETWEEN ONSET AND DEATH 12 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-23-61 to Jan 1, 1962 that (I) (we) last saw the deceased alive on Jan 1, 1962 , and that death occurred at 7:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE James H. Howell				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Catonsville				22d. ADDRESS 22d			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/1962		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Eaton Funeral Home				ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 4 '62	
						25b. REGISTRAR'S SIGNATURE William S. Thoma	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
CERTIFICATE OF DEATH

00345

M

1



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00343

CERTIFICATE OF DEATH
Item 2 Film G305 1/18/62 mh

00340

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> <u>Baltimore</u> 28	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>College Manor</u>		e. STREET ADDRESS <u>1009 Frederick Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine</u> First <u>Lotta</u> Middle <u>Ruppersberger</u> Last		4. DATE OF DEATH <u>1</u> <u>13</u> <u>1962</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/1877</u> <u>34</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>	
13. FATHER'S NAME <u>Gustave Henry Ruppersberger</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Schaefer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>I</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. Gustav H. Ruppersberger-5517 Roland Ave</u>	
17. INFORMANT <u>Mr. Gustav H. Ruppersberger-5517 Roland Ave</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>1 day</u> <u>5 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Viral nasopharyngitis and Bronchitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>September 12, 1958</u> to <u>January 13, 1962</u> that (I) (we) last saw the deceased alive on <u>January 12, 1962</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John N. Snyder</u> M.D.		22b. DATE SIGNED <u>January 13, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN N. SNYDER M.D.</u>		22d. ADDRESS <u>63482 FREDERICK RD BALTIMORE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-16-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Schaefer & Sons</u>		25a. REC'D BY REGISTRAR <u>JAN 15 '62</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Wm J. Schaefer</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

64809

It is very difficult to find a better name for this than "The Great Wall of China".

Handwritten text: *Handwritten text, possibly a signature or name, written in cursive script.*

CERTIFICATE OF DEATH

Reg. Dist. No.

00344

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AUGSBURG HOME		d. STREET ADDRESS 6811 Campfield Rd (7)	
3. NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last SAGER		4. DATE OF DEATH JAN 2 1962	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 8 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 1 Days 2 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) WINCHESTER VA		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Jacob S. BOWERS		14. MOTHER'S MAIDEN NAME SUSAN MELLINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT E.W. KATEWAMP		Address 6811 Campfield	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Cerebral Hemorrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (2) Hypertensive Heart Disease DUE TO (c) Generalized Arterio Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 8 hrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/19 , 19 59 , to Jan 2 , 19 62 , that I last saw the deceased alive on Jan 1 , 19 62 , and that death occurred at 12:00 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts. Balto. Md. DATE SIGNED 1/2/62	
PHYSICIAN'S NAME (Type) Earl L. Chambers		ADDRESS 4108 Liberty Hts. Balto. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF Jan 5, 62	22c. NAME OF CEMETERY OR CREMATORY Palmerwood	22d. LOCATION (City, town, or county) (State) Balto Md
23. FUNERAL DIRECTOR'S SIGNATURE W. Stehmann		ADDRESS 6067 Hayford Rd	
24a. REC'D BY REGISTRAR JAN 5 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

WE ARE NOT A COMPANY THAT SAYS "NO" TO ANYONE. WE ARE A COMPANY THAT SAYS "YES" TO EVERYONE.



CERTIFICATE OF DEATH

Reg. Dist. No. 00342

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3630 Coronado Rd. Zone 7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SALGANIK Last		4. DATE OF DEATH Month 1/11/62 Day 19 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1901
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Jewelery	11. BIRTHPLACE (State or foreign country) Phila., Pa.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gershon Salganik	
14. MOTHER'S MAIDEN NAME Rebecca Richmond		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 217/32/7059		INFORMANT Address Mrs. Mollie Salganik-- Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 3 days 9 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 11, 1962 to Jan 11, 1962 , that I last saw the deceased alive on Jan 11, 1962 , and that death occurred at 129 M from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6512 Liberty Road Baltimore 7, Md. ACTUAL SIGNATURE Marvin H. Davis M.D. PHYSICIAN'S NAME (Type) MARVIN H. DAVIS, M.D. 6512 Liberty Road Baltimore 7, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/12/62	22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cong	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC 6010 Reist Rd.		24a. REC'D BY REGISTRAR DATE JAN 17 '62	24b. REGISTRAR'S SIGNATURE Carling J. Hume

Page 4

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF TEXAS

1934

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

Bartholomew, Mary Jane

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00346 CERTIFICATE OF DEATH 00344											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 403 Glenmore Ave.						d. STREET ADDRESS 403 Glenmore Ave.					
3. NAME OF DECEASED (Type or print) Julia Schaefer						4. DATE OF DEATH Month January Day 31 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 7 1880		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 8 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Damm						14. MOTHER'S MAIDEN NAME Barbara Iager					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						17. INFORMANT Paul Schaefer-60 Bliss Lane, N. Wilberham, Mass					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardio-Vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 da 10 yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 e.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-31-1962 to 1-31-1962 that (I) (we) last saw the deceased alive on 1-31-1962 , and that death occurred 2:40 PM , from the causes and on the date stated above.											
22a. SIGNATURE Wilmer K. Gallagher						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 2-1-62		
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.						22d. ADDRESS 6209 Frederick Ave., Balt. 28, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-3-1962			23c. NAME OF CEMETERY OR CREMATORY St. Pauls Church Cemetery			23d. LOCATION (City, town or county) (State) Fulton, Howard Co; Md		
24. FUNERAL DIRECTOR'S SIGNATURE Edw. J. Mac...						ADDRESS 301 Frederick Rd. -28-			25a. REC'D BY REGISTRAR FEB 5 '62		
									25b. REGISTRAR'S SIGNATURE Charles S....		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00345

00347

1. PLACE OF DEATH a. COUNTY BALTO. CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONS VILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN E. SCHAEFER		4. DATE OF DEATH JAN 27 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-12-2265	
17. INFORMANT MADELINE SCHAEFER		Address 900 ELMRIDGE AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Decubitus Ulcers hips (c) & low Back marked severe			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1960 , 19 1/17/62 , that I last saw the deceased alive on 1/16/62 , 19 1/17/62 , and that death occurred at 500 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W E Mc Grath M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd DATE SIGNED 1/19/62	
PHYSICIAN'S NAME (Type) W E Mc Grath M.D.		Catonsville 28 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN 20, 1962	22c. NAME OF CEMETERY OR CREMATORY IMMANUEL LUTHERAN	22d. LOCATION (City, town, or county) (State) BALTO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE Bul E. Chawthorn Jr.		24a. REC'D BY REGISTRAR JAN 23 '62	
ADDRESS 3617 Chestnut AVE.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

<p>NAME OF DECEASED <i>John J. Smith</i></p>		<p>AGE <i>45</i></p>	
<p>SEX <i>Male</i></p>		<p>DATE OF BIRTH <i>Jan 15 1855</i></p>	
<p>PLACE OF BIRTH <i>Worcester, Mass.</i></p>		<p>DATE OF DEATH <i>Dec 10 1900</i></p>	
<p>CAUSE OF DEATH <i>Myocardial Infarction</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>DATE OF INTERMENT <i>Dec 12 1900</i></p>		<p>PLACE OF INTERMENT <i>St. John's Church</i></p>	
<p>NAME OF MINISTER <i>Rev. J. H. Smith</i></p>		<p>NAME OF CLERGYMAN <i>Rev. J. H. Smith</i></p>	
<p>NAME OF FUNERAL HOME <i>John J. Smith</i></p>		<p>NAME OF UNDERTAKER <i>John J. Smith</i></p>	
<p>NAME OF BURIAL PLACE <i>St. John's Church</i></p>		<p>NAME OF CEMETERY <i>St. John's Church</i></p>	
<p>NAME OF CITY <i>Boston</i></p>		<p>NAME OF COUNTY <i>Suffolk</i></p>	
<p>NAME OF STATE <i>Massachusetts</i></p>		<p>NAME OF COUNTRY <i>United States</i></p>	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00348

CERTIFICATE OF DEATH

00346

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>8212 Evergreen Drive</i>		d. STREET ADDRESS <i>8212 Evergreen Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Josephine Schleibaum</i>		4. DATE OF DEATH Month <i>January</i> Day <i>20th</i> Year <i>1962</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 31, 1886</i>
9. AGE (in years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR: Months <i></i> Days <i></i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Scotland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Willdridge</i>		14. MOTHER'S MAIDEN NAME <i>Mary Mc Dermott</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Norman Filler 8225 Evergreen Drive.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery disease</i> <i>420.1</i> DUE TO <i>Arteriosclerosis of the cardiovascular system</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
2Dc. TIME OF INJURY Hour <i></i> e.m. <i></i> p.m. <i>19</i>	2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	2Df. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3-29</i> , 19 <i>62</i> , to <i>1-20</i> , 19 <i>62</i> that (I) (we) last saw the deceased alive on <i>1-18</i> , 19 <i>62</i> , and that death occurred at <i>11AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>John T. Gould</i>		22b. DATE SIGNED <i>1-22-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>JOHN T. GOULD</i>		22d. ADDRESS <i>14 N. Easton - 24</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-24-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		25a. REC'D BY REGISTRAR <i>JAN 24 '62</i>	
25b. REGISTRAR'S SIGNATURE <i>William E. Hanna</i>			

1000000

UNITED STATES OF AMERICA

1000000



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

14
FOR STATE
HEALTH DEPT.

(M)

14

1

MEDICAL CERTIFICATION

2

03

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00349									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 3mth17dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Pikesville, Maryland d. STREET ADDRESS 4105 Colby Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Kathryn M. Schmitt					4. DATE OF DEATH Month January Day 2 Year 1962				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 27, 1884		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Nicholas Borzner					14. MOTHER'S MAIDEN NAME Mary Yerg				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old and new subdural hematomas DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Frequent falls DUE TO (c) Old age and senility								INTERVAL BETWEEN ONSET AND DEATH 2 months many years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell getting out of bed on 11-7-61 and sustained hematoma in the occipital region with small abrasion.						20c. TIME OF INJURY Month, Day, Year 11-7-61	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville 28, Maryland		20g. (County) Calvert		20h. (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Joseph R. Gladue		EXAMINER'S NAME (Type) Joseph R. Gladue, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/62		22c. NAME OF CEMETERY OR CREMATORY Hillside		22d. LOCATION (City, town, or country) Ardsley Pa		22e. (State) Pa	
23. FUNERAL DIRECTOR Frank H. Howell, Pikesville					24a. REC'D BY REGISTRAR DATE 4 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Huns		

10000

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

80348

(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00350					00348				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY Baltimore MARYLAND					a. STATE Maryland b. COUNTY Charles Co.				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Welcome, Maryland				
c. LENGTH OF STAY IN 1b 7yr9mth23dys					d. STREET ADDRESS none				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Maggie (.N.M.N.) Scott					4. DATE OF DEATH Month Day Year January 9 19 62				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 15, 1876		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Vernon R. Scott					14. MOTHER'S MAIDEN NAME Mary Clara Mattingly				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown			16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Catonsville		(County) (State)
21. I certify that (X) (this hospital) attended the deceased from March 16, 19 53 to Jan. 9, 19 62, that (X) (we) last saw the deceased alive on Jan. 9, 19 62, and that death occurred at 6:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Stella Wachslar M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 1-9-62			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.					22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/12/1962		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Church Cemetery, Hill Top, Maryland			23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Archart Funeral Home, Inc., La Plata, Md.					25a. REC'D BY REGISTRAR JAN 16 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

000000

000000



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

90

I

0

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00351

CERTIFICATE OF DEATH

Item 2 Film G307 2/14/62 iwk

00349

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridge Way Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> (unknown) d. STREET ADDRESS <u>Ridge Way Manor Nursing Home</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel</u> First <u>Seldon</u> Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-21-1881</u> 9. AGE (In years last birthday) <u>80</u> yrs. 10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS. Hours Min.		9. AGE (In years last birthday) <u>80</u> yrs. 10. UNDER 1 YEAR Months Days 11. UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>England</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Thomas Russell</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Mr. Fred Weisgal-10 E. Fayette Street</u> 17. INFORMANT Address <u>Mr. Fred Weisgal-10 E. Fayette Street</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO (b) <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>491X</u> DUE TO (c) <u>491X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Coronary Heart Disease</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>Jan 13 1962</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) extended the deceased from <u>Jan 13 1962</u> to <u>Jan 14 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 13 1962</u> , and that death occurred at <u>1:15</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Dr. Leon A. Kochman</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Dr. Leon A. Kochman</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1-13-62</u> 22d. ADDRESS <u>1214 N. Calvert St Baltimore Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-16-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>		25a. REC'D BY REGISTRAR <u>Jan 17 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

VR A15 (4)
15M 9/60

00351

00351

①

Handwritten notes and stamps, including "California" and "San Francisco".

Handwritten notes and stamps, including "San Francisco" and "California".

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00352					00350				
Item 4 Film G306 1/31/62 iwk									
1. NAME OF DECEASED (Type or Print) KATHERINE A. CLARK SHEESLEY					2. DATE OF DEATH 1/20/62				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <i>Baltimore County</i> FULL NAME OF HOSPITAL OR INSTITUTION Mery Villa Bellona Avenue (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 3 V 01-4 C. CITY OR TOWN Baltimore Co. 18, Md. (If outside city limits, write RURAL and give township) D. STREET ADDRESS 5612 Woodmont Ave. Mercy Villa-6800 Bellona Ave. (If rural, give location)				
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9/18/1880	9. AGE (In years last birthday) 81	If Under 1 Year Months Days		If Under 24 Hours Hours Min.		
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME THOMAS CLARK					14. MOTHER'S MAIDEN NAME KATHERINE NORTON				
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) no			16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Mr. J.N. Flynn-5516 Woodmont Ave. 12				
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 422.1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) Broncho pneumonia DUE TO (B) Arteriosclerotic cardio vascular disease DUE TO (C) 5 years					INTERVAL BETWEEN ONSET AND DEATH 4 days				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I ON PAGE II			19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22. I certify that (I) (the hospital) attended the deceased from December 24, 1961 to January 19, 1962 , that (I) (we) lost saw the deceased alive on January 18, 1962 , and that in (my) (our) opinion death occurred at 6:00A.m. , from the causes and on the date stated above.									
23A. SIGNATURE Philip A. Flynn ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.			23B. ADDRESS 11 E. Chase Street			23C. DATE SIGNED 1-22-62			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/23/62	24C. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		24d. LOCATION (City, town, or county) (State) Balto. City				
25A. DATE REC'D BY HEALTH DEPT. JAN 23 62			25b. NAME OF REGISTRAR Arthur S. Adams		25C. FUNERAL DIRECTOR ADDRESS WIEDEFELD & SON-Greenmount & 22nd				

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00354

00352

1. PLACE OF DEATH a. COUNTY BALTO MORE MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OWINGS MILLS c. LENGTH OF STAY IN lb 7 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROSEWOOD STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 2103-2 d. STREET ADDRESS 113 E. FRANKLIN STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHY Middle SUE Last SHRADER		4. DATE OF DEATH Month 1 Day 22 Year 1962					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-59	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 22	IF UNDER 24 HRS. Hours 19 Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON - MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM EDWARD Shrader			14. MOTHER'S MAIDEN NAME SARAH ELLEN WEBB				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT HOSPITAL CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4 93X DUE TO (b) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 19 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Microcephaly, spastic quadriplegia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (if (this hospital) attended the deceased from May 4, 1961 to Jan 22, 1962 , that (I) (we) last saw the deceased alive on Jan 22, 1962 , and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Edward J. Mathews		22b. DATE SIGNED 1-22-62		22c. PHYSICIAN'S NAME (Type) EDWARD J. MATHEWS		22d. ADDRESS Rosewood State Training School Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/24/62		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown		24a. ADDRESS Wm. A. Short		25a. REC'D BY REGISTRAR JAN 25 '62		25b. REGISTRAR'S SIGNATURE C. H. S. Kenna	

M

DATE HERE

OWNER'S NAME

ADDRESS

THE PROPERTY

PROPERTY NO.

PROPERTY STATE

115 E. Franklin Street

NAME

AGE

SEX

1

2

3

W

W-25-07

W-25-07

W-25-07

W-25-07

NAME

W-25-07

W-25-07

WILLIAM EDWARD SAMPSON

W-25-07

W-25-07

W

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

W-25-07

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00355 CERTIFICATE OF DEATH 00353

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore 17 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17 d. STREET ADDRESS 2031 McCulloh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howard T. Smith		4. DATE OF DEATH Month Day Year January 5 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18 1904
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef-Cook		10b. KIND OF BUSINESS OR INDUSTRY Restuarant	
11. BIRTHPLACE (County & State, or foreign country) Kissimmee, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daisy Moore		14. MOTHER'S MAIDEN NAME Daisy Moore	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 263-10-8243	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE, ACUTE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LEFT LOWER LOBE PNEUMONIA (c) HYPERTENSIVE CARDIOVASCULAR DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUODENAL ULCER GASTRIC ULCER	
19. INTERVAL BETWEEN ONSET AND DEATH 12 Days		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from Dec. 26, 1961, to Jan. 5, 1962, that X (we) last saw the deceased alive on Jan. 5, 1962, and that death occurred at 9:30 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Frederick S. Donaldson M.D.		22b. DATE SIGNED 1/6/62	
22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, Balto. 18 Md., Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/9/62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		25a. REC'D BY REGISTRAR DATE JAN 9 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Thomas			

10353



1000 Franklin Ave.
Baltimore, Md.

RENT O. WILSON

Frederick S. Dore

11/1/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4, retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

50

I

0

1

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00356

CERTIFICATE OF DEATH

00354

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 569			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2 3401-4			
f. STREET ADDRESS 723 Harford Avenue				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (Also WILLIAM WILLIE) First Middle Last SMITH SMITH				4. DATE OF DEATH Month Day Year January 20 19 62			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1899	
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Waggam, Louisiana	
13. FATHER'S NAME Henry Smith				14. MOTHER'S MAIDEN NAME Josephine Bush			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I			
17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland VAH, FORT HOWARD DIVISION							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 581.1 DUE TO LAENNEC'S CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 30 1960 to January 20 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 20 1962 , and that death occurred at 11:15 M, from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert JOHN D. TALBERT, M.D. Medical Service				22b. DATE SIGNED 1/22/62			
22c. PHYSICIAN'S NAME (Type) Acting Chief,				22d. ADDRESS VAH, BALTIMORE 18 MD., FT. HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-26-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Ave., Balto. 17, Md.				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 31 '62 Arthur S. Evans			



Fort Howard

Veterans Administration Hospital

(Also known as)

Hogto

Cook

Restonville

U. S. A.

Henry S. Smith

W. I.

U. S. A.

U. S. A.

July 30, 1962

January 30, 1962

U. S. A.

U. S. A.

U. S. A.

U. S. A.

Julius S. Kraus

VR A15 (4)
15M 7/61

220

Воскресенье 10-го апреля 1900 года. - 10-е апр.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> c. LENGTH OF STAY IN lb <u>3 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1321 Pine Grove Ave.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u> d. STREET ADDRESS <u>1321 Pine Grove Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marie F.</u> Middle <u>Margaret</u> Last <u>SOISTMAN</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22 1985</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Fuller</u>	
14. MOTHER'S MAIDEN NAME <u>Sophia Schreiber</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>217-09-1771</u>		17. INFORMANT Address <u>Herbert M. Soistman 1321 Pine Grove Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO <u>Arteriosclerotic Cardiovascular Disease & Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February 15, 1960</u> to <u>January 15, 1962</u> , that I last saw the deceased alive on <u>Jan 15, 1962</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Orth</u>		ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd. Philadelphia, Pa.</u> DATE SIGNED <u>Jan 16, 1962</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-18-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Coach</u>		24a. REG. BY REGISTRAR <u>JAN 18 1962</u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

Philip F. Cook 1st Class

General 1-18-24 New Orleans County 13-18-24

John F. Cook 2nd Class

1894

John F. Cook 2nd Class

John F. Cook 2nd Class

John F. Cook 2nd Class

John F. Cook 2nd Class

John F. Cook 2nd Class

Joseph Fuller

Hosanna

Female White

1882 1882 1882

John F. Cook 2nd Class

1882

Monaghan

Joseph Fuller

217-02-1311 Hunt in 2nd Class 1882

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00357

00359

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb 13 X - 2 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS St. Johns Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUST Middle SONNTAG Last		4. DATE OF DEATH Month January Day 25 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1885
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Chicken	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Forest Haven Records	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CHANGES - CORONARY 422.1 DUE TO DISEASES - PULMONARY EMBOLISM Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO PERICARDITIS (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1 , 1961, to 1/25 , 1962 that I last saw the deceased alive on 1/25 , 1962, and that death occurred at 9:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Shaw M.D. 550 E. MUNDANNAVE 1/26/62 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) John H. Shaw M.D. BALD. 28, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-29-62	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, MD	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE JAN 29 '62	
24b. REGISTRAR'S SIGNATURE Richard L. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1906

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE

1905

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00358

00350

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6528 CORKLEY Rd.		d. STREET ADDRESS 16528 CORKLEY Rd.	
3. NAME OF DECEASED (Type or print) MARYANNA First Middle Last		4. DATE OF DEATH JANUARY 8 Month Day Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7-1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? POLAND ✓	
13. FATHER'S NAME MICHAEL CHMIELEWSKI		14. MOTHER'S MAIDEN NAME MARGARET CHES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-1046	
17. INFORMANT AGNES KRUS Address 6528 CORKLEY Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial hypertensive Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Atrial fibrillation			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1-3-62 , 19 62 , to Jan 3-62 , 19 62 , that I last saw the deceased alive on 1-3- , 19 62 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr John Geldrich		ADDRESS (Street, city or town, state) 8019 Philadelphia Road Baltimore 6, Maryland	
PHYSICIAN'S NAME (Type) John Geldrich, M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/10/62	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	22d. LOCATION (City, town, or county) (State) 6515 Boston St-Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber ADDRESS 705 S. Ann st		24a. REC'D BY REGISTRAR JAN 9 '62 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Henth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00361

CERTIFICATE OF DEATH

100359

1. PLACE OF DEATH a. COUNTY <u>BALTO Co</u> <u>27</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO HIGHLANDS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO HIGHLANDS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2838 TENNESSE AV.</u>				d. STREET ADDRESS <u>2838 TENNESSE AV</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NETTIE R. STANKO</u>				4. DATE OF DEATH Month Day Year <u>1 16 1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUTMAN'S</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>John P. Stanko</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>44-3X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 13, 1952</u> to <u>JAN. 16, 1962</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>JAN. 13, 1962</u> , and that death occurred at <u>HOME</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>C. Arthur Rossberg MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG MD</u>				22d. ADDRESS <u>2436 WASHINGTON BLVD. BALTO-30 MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Glen Burnie, MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Luman & Son Inc. Balto 23, MD</u>				25a. REC'D BY REGISTRAR <u>JAN 18 62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be filed with the hospital or funeral home. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be filed with the hospital or funeral home.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

00301

PAID TO THE ORDER OF
2338 Tennesse

KEITH
F W
124

GEORGE
JAN 10 1912
124

PAID TO THE ORDER OF
2338 Tennesse

PAID TO THE ORDER OF
2338 Tennesse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00362

00360

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 13 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2719 Huntington Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERNARD M. STARR		4. DATE OF DEATH Month January Day 3 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1890 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
13. FATHER'S NAME James Starr		14. MOTHER'S MAIDEN NAME Catherine Maker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 218-10-7595	
17. INFORMANT Clinical Records, VAH, Fort Howard Division		Address Baltimore 18, Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (b) ENCEPHALOMALACIA, RIGHT CEREBRUM (c) ARTERIOSCLEROTIC HEART DISEASE		RECENT UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		
BENIGN PROSTATIC HYPERTROPHY		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 21, 1961 to January 3, 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 3, 1962 , and that death occurred at 3:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Thomas F. Crahan		22b. DATE SIGNED 1/13/62	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO. 18 MD FT HOWARD DIVISION	

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-5-62	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE 6009 Harford Road		25a. REC'D BY REGISTRAR JAN 4 '62	25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

Wh. Cook-Blight, Inc., Baltimore 14, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

01362



100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

100-10000

Handwritten signature

100-10000

100-10000

100-10000

100-10000

1
after
the law requires that the death certificate be executed within 24 hours after death by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div>1</div> <div>00363</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>00361</div>									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Alleghany ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 0102-2			d. STREET ADDRESS 1019 Frederick Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Barbara Jo Stitcher					4. DATE OF DEATH Month 1 Day 18 Year 1962				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/18/48		9. AGE (In years last birthday) 13 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Henry Stitcher					14. MOTHER'S MAIDEN NAME Carmel Rosemary Stitcher				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no					16. SOCIAL SECURITY NO. none				
17. INFORMANT Rosewood Records, Owings Mills, Maryland					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA (LEFT LOWER LOBE) DUE TO (b) complicating long standing (c) hydrocephalus. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
INTERVAL BETWEEN ONSET AND DEATH 1 week									
Birth									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (H) (this hospital) attended the deceased from 12/13 , 19 61 to 1/18 , 19 62 , that (H) (we) last saw the deceased alive on 1/18 , 19 62 , and that death occurred at 7:45 p.m. the causes and on the date stated above.									
22a. SIGNATURE Harry G. Butler					22b. DATE SIGNED 1/19/62				
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.					22d. ADDRESS Rosewood Lane, Owings Mills, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/22/62		23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George					25. REC'D BY REGISTRAR DATE JAN 22 '62				
ADDRESS Cumberland, Md.					25b. REGISTRAR'S SIGNATURE Arthur J. K...				

VR A15 (4)
15M 9/60



80368

CERTIFICATE OF BIRTH

Butler 1/1/1912
L. Wayne George Chamberlain, No.

Greenmount Cemetery

George J. Butler

Photograph of George J. Butler

George J. Butler (see reverse)

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

George J. Butler

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #7 - Film G305 - 1/24/62-mmb

00364

CERTIFICATE OF DEATH

Reg. Dist. No.

00362

1. PLACE OF DEATH o. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <u>Md.</u> b. COUNTY <u>Balto. A.A.Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Louison</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u>		02 X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women & Aged Men's Home</u>				d. STREET ADDRESS <u>417 Forth St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Amelia</u> Middle <u>C</u> Last <u>Suit</u>				4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/1876</u>	9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes, U.S.A.</u>	
13. FATHER'S NAME <u>David Drohan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Sally E. Hamilton, 615 Chestnut Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>425.1</u> <u>Arteriosclerosis Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerosis Cardio-vascular Disease</u> DUE TO (c) <u>Arteriosclerosis Sanguine at first 48 hrs.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>45</u> , to <u>Jan 20</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>January 19</u> , 19 <u>62</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Newland E. Day</u> M.D. <u>H-E-33rd St Baltimore Md Jan 20, 1962</u> PHYSICIAN'S NAME (Type) <u>Newland E. Day, M.D.</u> <u>4 East 33rd Street, Baltimore 18</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<u>BURIAL</u>	<u>1-23-62</u>	<u>Cedar Hill Cemetery</u>		<u>5829 Ritchie Highway, Zone 25</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(continued from page 6)

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VR A15 (4)
15M 9/59

1
M

90

1

0

1

1
M
00365

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00363

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Allegheny</i> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>				c. LENGTH OF STAY IN 1b <i>6 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i> <i>0102-2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maryland Masonic Home</i>				d. STREET ADDRESS <i>315 Frederick St.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Edward Milton Sutton</i>				4. DATE OF DEATH Month Day Year <i>Jan 10 1962</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Aug 6, 1869</i>	
9. AGE (In years lost birthday) <i>92 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Storekeeper</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>General Store</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>							
13. FATHER'S NAME <i>Joseph H Sutton</i>				14. MOTHER'S MAIDEN NAME <i>Rachel S Supler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>217-10-7531</i>		17. INFORMANT Address <i>Records Masonic Home Cockeysville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-vascular disease</i> 4-22-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 19 1961</i> to <i>Jan 10 1962</i> , that (I) (we) last saw the deceased alive on <i>Jan 9 1962</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Elizabeth B. Sherrill</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/10/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherrill, M.D.</i>				22d. ADDRESS <i>Cockeysville Md.</i>			
23a. BURIAL, CREMATION, or other disposition (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>1-13-62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Pikesville</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</i>				ADDRESS <i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 11 '62</i>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krawe</i>			

CERTIFICATE OF DEATH

1962

(M)

1962-12-14

1962-12-14

6742

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

1962-12-14

CHILDREN

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00366

00364

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 8½ months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 3306 Clifftmont Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul		First Paul		Middle Lee		Last Sweetman	
4. DATE OF DEATH 1		Month 1		Day 3		Year 19 62	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/30/1898	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Repairman		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Sweetman				14. MOTHER'S MAIDEN NAME Katherine Lucas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-05-0470		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of lung							INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/11/61 4:15 p.m. 1/3/62 , 19____, that (I) (we) lost the deceased alive on 1/3/62 , 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE Wm. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/3/62	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/6/62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek				25a. REC'D BY REGISTRAR DATE JAN 5 '62		25b. REGISTRAR'S SIGNATURE Charles E. Schimunek	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00367 Item 4 Film G305 1/11/62 jwk

00365

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 24 Gorsuch Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium d. STREET ADDRESS 24 Gorsuch Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sarah Elizabeth Swint		4. DATE OF DEATH January 5 1962		5. SEX Female 6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Nov. 8, 1883		9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Georgia			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Walker		14. MOTHER'S MAIDEN NAME Isabelle Bealer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1		17. INFORMANT Mrs. Carolyn S. Koenig-24 Gorsuch Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardiovascular Disease DUE TO (c) Disease INTERVAL BETWEEN ONSET AND DEATH 3 days				PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 3 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from July 1957 to Jan 4 1962 , that (I) (we) last saw the deceased alive on Jan 4 1962 and that death occurred at 7:30 A.M. from the causes and on the date stated above.					
22a. SIGNATURE George T. Gilmore M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/5/62			
22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE, MD		22d. ADDRESS LANHAM BUILDING LUTHERVILLE					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-6-62		23c. NAME OF CEMETERY OR CREMATORY Powell Church Cemetery			
23d. LOCATION (City, town or county) Harlem, Georgia		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Johnson & Son Balto. Md		ADDRESS		25a. REC'D BY REGISTRAR JAN 8 '62			
25b. REGISTRAR'S SIGNATURE William S. Thoms		DATE					

MEDICAL CERTIFICATION

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled by the funeral director. After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00358

CERTIFICATE OF DEATH

Items 8 & 9 Film G306 2/1/62 iwk

00356

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 516 Gun Rd.		d. STREET ADDRESS 516 Gun Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD H. TAGGART SR.		4. DATE OF DEATH Month Day Year Jan. 26, 1962 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1876
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel M. Taggart		14. MOTHER'S MAIDEN NAME Sarah Schlosser	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Ross S. Hosmer, 508 Gun Rd. Balto. 27, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 Congestive Heart Failure secondary to DUE TO (b) Carcinoma of the Liver with jaundice Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arterio-sclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1/30, 1961 to 1/26, 1962 that (I) (we) last saw the deceased alive on 1/26, 1962 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James N. Frederick MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 1311 Francis Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/62	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107		25a. REC'D BY REGISTRAR JAN 31 '62	
ADDRESS Wilkins Avenue #29		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

90332

Ballistics

July

110 Gun No.

HOWARD H. HOBBS, JR.

1000 N. 10th St.

St. Paul, Minn.

James H. Hobbs

James H. Hobbs

1000 N. 10th St., St. Paul, Minn.

Commissioner of the State

Department of Corrections

1000 N. 10th St.
St. Paul, Minn.

James H. Hobbs

Howard H. Hobbs 4107 W. Wilkins Avenue 113

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00369

00367

1. PLACE OF DEATH a. COUNTY Balto.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wards Chapel		c. LENGTH OF STAY IN 1b 4 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home		d. STREET ADDRESS 802 Milford Mill Road	
3. NAME OF DECEASED (Type or print) Grace P. Tasker		4. DATE OF DEATH Jan/ 19, 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> Married	8. DATE OF BIRTH 3-14-1869
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Caleb Pitkin		14. MOTHER'S MAIDEN NAME Flavia Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 12-1-1869	
17. INFORMANT Mrs. Matthew H. Bradway		Address Pikesville 8, Md. 802 Milford Mill Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10-20 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/2/60 , 19....., to 1/2/62 , 19....., that (I) (we) last saw the deceased alive on 1/12/62 , 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Milton Schlenoff		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Milton Schlenoff		22d. ADDRESS 6410 Windsor Mill Road, Balto. 7	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-22-1962	
23c. NAME OF CEMETERY OR CREMATORY Valley Cemetery		23d. LOCATION (City, town or county) (State) Manchester, New Hampshire	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		25a. REC'D BY REGISTRAR DATE JAN 24 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Travis			

23505



• 05 Feb

• 02/14/20

11. Frank

2520 4

Is not the case

Each ID bottle has

Charles Hall, President

51

2.5

1088

2957

35

0061-51-5

222

Xin Liang

1966

● ● ●

signific

3000

© 1999 Blackwell Science Ltd

2017 2101

1914-15

11-11-11

808 yampani . 8 wendro . 27

SAID ANDERSON WILL SEND, BELLEVILLE, ILL.

[illegible]

SECRET

Copyright © 1999 by John Wiley & Sons, Inc.

15001-85-1

1998

8278 Library of Congress

• 100 •

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00370

00368

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 7 Hours; 15 Min. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 321 East 24th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) William -- Taylor				4. DATE OF DEATH Month January Day 12 Year 1962													
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-6-89		9. AGE (In years last birthday) 72 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman				10b. KIND OF BUSINESS OR INDUSTRY Fishing		11. BIRTHPLACE (County & State, or foreign country) Tazewell Co Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Major Taylor				14. MOTHER'S MAIDEN NAME Sarah Smith													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW-1				16. SOCIAL SECURITY NO. 231-10-1012		17. INFORMANT Address Clin Rec VAH Baltimore Md - Ft Howard Division											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <table border="1" style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC PASSIVE CONGESTION OF LUNGS AND LIVER </td> <td rowspan="3"> INTERVAL BETWEEN ONSET AND DEATH UNKNOWN </td> </tr> <tr> <td rowspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td> DUE TO (b) CARDIAC INSUFFICIENCY </td> <td> UNKNOWN </td> </tr> <tr> <td> DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE </td> <td> UNKNOWN </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC PASSIVE CONGESTION OF LUNGS AND LIVER		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) CARDIAC INSUFFICIENCY	UNKNOWN	DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE	UNKNOWN		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC PASSIVE CONGESTION OF LUNGS AND LIVER		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b) CARDIAC INSUFFICIENCY		UNKNOWN														
	DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		UNKNOWN														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ARTERIOSCLEROSIS, GENERALIZED. ADENOMA, TAIL OF PANCREAS								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that X (this hospital) attended the deceased from Jan. 12, 1962 to Jan. 12, 1962 , that X (we) last saw the deceased alive on Jan. 12, 1962 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.																	
22a. SIGNATURE Donald W. Stewart M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-14-62											
22c. PHYSICIAN'S NAME (Type) DONALD W. STEWART, M.D.				22d. ADDRESS VAH Baltimore 18 Md-Ft Howard Division													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson				25a. REC'D BY REGISTRAR JAN 19 1962		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00371

00369

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4230 Chapel Road				d. STREET ADDRESS 4230 Chapel Road			
3. NAME OF DECEASED (Type or print) John Sebastian Thim				4. DATE OF DEATH Month 1 Day 2 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-4-1889		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Message Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad Retired		11. BIRTHPLACE (County & State, or foreign country) Balto. City Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Sebastian Thim				14. MOTHER'S MAIDEN NAME Catherine Rudel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W I		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Perry Hall Md Mrs Margaret Luckert 4320 Chapel Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Insufficiency DUE TO (b) Hypertensive Cardio-cerebral Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Anteroseptal Myocardial Infarct INTERVAL BETWEEN ONSET AND DEATH 3 mos 12 years 10 weeks						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/28 , 19 61 , to 1/2 , 19 62 , that (I) (we) last saw the deceased alive on 12/28 , 19 61 , and that death occurred at 1:15 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John H. Hirschfeld M.D. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/4/1962	
22c. PHYSICIAN'S NAME (Type) JOHN H. HIRSCHFELD M.D.				22d. ADDRESS 6919 HARFORD Road, Balto 14 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-5-1962		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road				25a. REC'D BY REGISTRAR DATE JAN 5 '62		25b. REGISTRAR'S SIGNATURE Arthur L. France	

CERTIFICATE OF DEATH

1950

Name of Deceased		John	
Sex		Male	
Age		45	
Date of Birth		1905-10-15	
Place of Birth		New York, N.Y.	
Cause of Death		Heart Disease	
Date of Death		1950-11-10	
Place of Death		New York, N.Y.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		1950-11-15	
Place of Registration		New York, N.Y.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **00370**

00372

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boxerhill Rd.				d. STREET ADDRESS Boxerhill Rd., Box 325A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ROLAND Middle HARRISON Last THOMAS				4. DATE OF DEATH Month Jan. Day 26 Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1889		
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		
10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John Thomas				14. MOTHER'S MAIDEN NAME Catherine Stover				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-22-0820		17. INFORMANT Address Gladys M. Thomas, Boxerhill Rd., Cockeysville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none		
21. I certify that I attended the deceased from <u>12-22-58</u>, 19<u> </u>, to <u>1-26-62</u>, 19<u> </u>, that I last saw the deceased alive on <u>7-14-61</u>, 19<u> </u>, and that death occurred at <u>6</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 1-26-62								
ACTUAL SIGNATURE D. D. Caples				PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan. 29, 1962		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		
22d. LOCATION (City, town, or county) (State) Pikesville, Md.				23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Frank H. Newell, Pikesville 8, Md.				
24a. REC'D BY REGISTRAR DATE JAN 30 '62				24b. REGISTRAR'S SIGNATURE Arthur S. Evans				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the registrar. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00373

00371

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 136 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 23 d. STREET ADDRESS 2346 Frederick Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM H. THOMPSON, SR.		4. DATE OF DEATH Month Day Year January 11 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 17, 1897 64
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11. BIRTHPLACE (County & State, or foreign country) Buffalo, New York	
13. FATHER'S NAME Jack Thompson		14. MOTHER'S MAIDEN NAME Mary Murphy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 218-01-6345	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRAIN TUMOR (GLIOMA) BOTH FRONTAL LOBES DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BENIGN PROSTATIC HYPERTROPHY		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 28 19 61 to January 11 19 62 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 11 19 62 , and that death occurred at 7:35 A.M. from the causes and on the date stated above.	
22a. SIGNATURE Thomas F. Crahan, M.D.		22b. DATE SIGNED 1/11/62	
22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTO 18 MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-15-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md.		25a. REC'D BY REGISTRAR JAN 15 '62	
25b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

VR A15 (4)
15M 9/60

689

Indice: [Indice](#)

HAZARD

•

.. 32, KOF 41112

2. *Impact of the 1997-1998 Asian Crisis*

40 FBI VI 1000000

Call: 1-800-222-2222

• A • B • C

RECEIVED

1. PLACE OF BIRTH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; live if deceased lived) b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 2 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 Welford Road Lutherville, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GORDON		4. DATE OF DEATH January 20 19 62	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1952	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School child		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Raymond T. Tippitt	
14. MOTHER'S MAIDEN NAME Helen Almeda Morrison		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT R. B. Lownes	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Asphyxia carbon monoxide poisoning DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 916 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Conflagration in home		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Jan. 20 19 62		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in home	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. Jan. 20 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 115 Welford Road		20f. (City or town) (County) (State) Balto. Co. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-62	
22c. NAME OF CEMETERY OR CREMATORY St. Timothy's Cms		22d. LOCATION (City, town, or country) (State) Philadelphia Pa	
23. FUNERAL DIRECTOR Richard D Lownes		24a. REC'D BY REGISTRAR DATE JAN 23 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS (Street, city, town, or county) Lafayette	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0037:

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY	Baltimore County	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE	Maryland	b. COUNTY	Baltimore									
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Lutherville	c. LENGTH OF STAY IN lb	2 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Lutherville	d. STREET ADDRESS	113 Welford Rd								
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	113 Welford Rd	e. IS RESIDENCE ON A FARM?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4. DATE OF DEATH	Month	Day	Year								
	3. NAME OF DECEASED (Type or print)	MATTHEW	5. SEX	male	6. COLOR OR RACE	white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	2	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	NONE	11. BIRTHPLACE (State or foreign country)	Pennsylvania	12. CITIZEN OF WHAT COUNTRY?	U.S.A.
	13. FATHER'S NAME	Raymond T. Tippet	14. MOTHER'S MAIDEN NAME	Helen Almeda Morrison	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	NO	16. SOCIAL SECURITY NO.	NONE	17. INFORMANT	Address Lafayette Hill, Pa.						
	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Asphyxia	916	DUE TO	carbon monoxide poisoning	INTERVAL BETWEEN ONSET AND DEATH									
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	third degree burns	19. WAS AUTOPSY PERFORMED?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
	20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	Conflagration in home	20c. TIME OF INJURY	Month, Day, Year	Jan. 20 19 62	20d. INJURY OCCURRED	While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	115 Welford Road	20f. (City or town)	Baltimore Co. Md.				
	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	ACTUAL SIGNATURE	Russell S. Fisher	EXAMINER'S NAME (Type)	Russell S. Fisher, M.D.	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED	Jan. 20, 1962						
	22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)	23. FUNERAL DIRECTOR	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE									
Burial	1-24-62	St. Simon the Apostle	Philadelphia Pa.	Richard D Lowers	JAN 23 '62	Arthur S. Fisher										

100-1111
RECEIVED



RECEIVED
FEB 11 1952
FBI - NEW YORK

RECEIVED
FEB 11 1952
FBI - NEW YORK

Interview

2 years

1111 Reform Rd

1111 Westford

NONE

NONE

Pennsylvania

NO

NONE

R. E. Lowes Germanown Pike

Raymond F. Tappett

Lafayette Hill,

Robert S. Tappett

Robert S. Tappett
1111 Westford
1111 Reform Rd

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00376

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G305 1/26/62 iwk

00374

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville	
c. LENGTH OF STAY in 1b 2 yrs		d. STREET ADDRESS (same) 115 Welford Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 Welford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Paul Tippet		4. DATE OF DEATH Month Day Year January 20 19 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1954
9. AGE (In years last birthday) 7 yrs.		10. IF UNDER 1 YEAR Months Days 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Child		10b. KIND OF BUSINESS OR INDUSTRY School	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond T. Tippet		14. MOTHER'S MAIDEN NAME Helen Almeda Morrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT R. D. Lownes		Address Germantown Pike Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning 916-0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Jan. 20 1962	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 115 Welford Rd.	20f. (City or town) (County) (State) Baltimore Co. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 20, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-62	22c. NAME OF CEMETERY OR CREMATORY St. Timothy's Cem.
22d. LOCATION (City, town, or country) (State) Philad. Penna.		24a. REC'D BY REGISTRAR Richard D. Lownes	
23. FUNERAL DIRECTOR Richard D. Lownes		24b. REGISTRAR'S SIGNATURE Lafayette Hill, Pa.	
DATE JAN 23 '62			

100-100000

100-100000

100-100000

Interstate

2 yrs

113 Western Road

(code) 113

April 24, 1954

School

School Child

Pennsylvania

No

None

None

F. D. Downer Germantown Pike

Lafayette

Handwritten signature

100-100000

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00377 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00375

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY in 1b 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Welford Rd.				d. STREET ADDRESS 113 Welford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond T Tippet				4. DATE OF DEATH Jan. 20th 1962			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1927		9. AGE (In years last birthday) 34 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chain Belt		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond Tippitt				14. MOTHER'S MAIDEN NAME Bancroft			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Richard D. Lownes		17. INFORMANT Lafayette, Pa Germantown Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2nd degree burns							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in home					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1/20 62 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 115 Welford Rd.		20f. (City or town) (County) (State) Balto. Co., Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> . ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> . DEPUTY MEDICAL EXAMINER <input type="checkbox"/> . DATE SIGNED January 20, 1962							
ACTUAL SIGNATURE Russell S. Fisher		M.D. Russell S. Fisher, M. D.					
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		Address (Street, city, town, or county) January 20, 1962					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-62		22c. NAME OF CEMETERY OR CREMATORY St. Timothy Cmn.		22d. LOCATION (City, town, or county) (State) Philadelphia Pa.	
23. FUNERAL DIRECTOR Richard D Lownes				ADDRESS Lafayette Hill Pa.		24a. REC'D BY REGISTRAR AN 23 '62	
				24b. REGISTRAR'S SIGNATURE Richard S. Lownes			



William County

2 VTB

Hamlet

13 National Road

111. 111. 111.

June 2, 1937

White

Chain belt

Pennsylvania

Raymond L. Smith

Yes

Richard A. Jones

Section 100-101-102

San George

Continuation in form

111. 111. 111.

Richard A. Jones

111. 111. 111.

January 20, 1937

Richard A. Jones
11-24-37
Continuation in form

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00378

CERTIFICATE OF DEATH

00376

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 16 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>_____</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 15 d. STREET ADDRESS 5460 Lynview Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>---</u> Last <u>TOLLY</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 23, 1887</u> 9. AGE (in years last birthday) <u>74</u> yrs. 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min. 11. BIRTHPLACE (County & State, or foreign country) <u>Poland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman 10b. KIND OF BUSINESS OR INDUSTRY Automobile Radiators 14. MOTHER'S MAIDEN NAME Dena Tanenbaum			
13. FATHER'S NAME Jonas Markowitz 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes <u>WW I</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> 446X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>CHRONIC NEPHRITIS</u> DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CHRONIC BRAIN SYNDROME, SECONDARY TO ARTERIOSCLEROSIS 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (1) (this hospital) attended the deceased from <u>January 8, 1962</u> , to <u>January 24, 1962</u> , that (2) (we) last saw the deceased alive on <u>Jan. 24, 1962</u> , and that death occurred at <u>2:07 P.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Freeman</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>1/24/62</u> 22c. PHYSICIAN'S NAME (Type) <u>IRVING FREEMAN, M.D. Medical Service</u> 22d. ADDRESS <u>VAH, BALTO 18 MD FT HOWARD DIVISION</u>			
23a. IRVING, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan. 25, 1962 23c. NAME OF CEMETERY OR CREMATORY Anshe Emunah Congregation 23d. LOCATION (City, town or county) (State) Baltimore Maryland				24. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Sons ADDRESS 6010 Reisterstown Rd. Balto. Md 25a. REC'D BY REGISTRAR JAN 29 '62 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

0373



Refugee

John Howard

10 days

Refugee 15

Victor and Adeline (Sons)

5400 Irving Avenue

John

John

January

1932

John

John

15

Refugee

Refugee

U. S. A.

John

John

Charles Howard, Van, William H. Howard
PORT HOWARD DIVISION

NAME

15

15

15

NAME

CHRONIC NEURALGIA

CHRONIC

CHRONIC NEURALGIA, REMITTENT

CHRONIC

CHRONIC NEURALGIA, REMITTENT

January 15, 1932

January 15, 1932

Jan. 15

VAN, EDWARD 15 15 15 HOWARD DIVISION

EDWARD, M. D. Howard Division

Refugee

Anna Howard Congregation

Refugee

Edwin S. Howard 15 15 15

CERTIFICATE OF DEATH

Reg. Dist. No.

111377

00379

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4414 Glenmore Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Otto		First		Middle		Last	
4. DATE OF DEATH Januray 3, 19 62		Month		Day		Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1888		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Martin Urban				14. MOTHER'S MAIDEN NAME Hattie Schreiber			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 213-05-0310 A		INFORMANT John Urban 4414 Glenmore Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hr 5 yr						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-3 , 19 62 , to 1958 , that I last saw the deceased alive on 1-3 , 19 62 , and that death occurred at 11:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul G. Mueller		ADDRESS (Street, city or town, state) 6411 BELAIR ROAD 1-562					
PHYSICIAN'S NAME (Type) PAUL G. MUELLER		DATE SIGNED BALTIMORE, #6 MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/62		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR DATE JAN 10 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHURCH OF CHRIST

1900



RECEIVED OF DEAR

00000

10000

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

1 FOR STATE HEALTH DEPT. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00379

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 13 1/2 years		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix Jacksonville		d. STREET ADDRESS Sweet Air Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) JOHN ADOLPH WALKER		4. DATE OF DEATH Month 1		Day 19		Year 19 62		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1895		9. AGE (In years last birthday) 66 1/2		10. IF UNDER 1 YEAR Months 6		Days 6		Hours 6		Min. 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy, Ret		10b. KIND OF BUSINESS OR INDUSTRY Black and Navy Decker Co.		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ellina Walker ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I & WW II		16. SOCIAL SECURITY NO. 219-28-7272		17. INFORMANT Mrs. Marie Walker Sweet Air Rd Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Coronary Occlusion Sudden		INTERVAL BETWEEN ONSET AND DEATH Sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																									
ACTUAL SIGNATURE Charles T. Howard M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Address (Street, city, town, or county) (State)																									
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried				22b. DATE THEREOF 1-23-1962				22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or country) Arlington, Virginia													
23. FUNERAL DIRECTOR Brooks Funeral Service, Inc Towson Md										24a. REC'D BY REGISTRAR JAN 23 '62				24b. REGISTRAR'S SIGNATURE Arthur L. Hays											

IN STATE
DEPARTMENT

Baltimore

Baltimore

Baltimore

James Jacksonville 19 years 1900-1919

Sweet Air Road Jacksonville, Fla Sweet Air Road

Film 1305-1/12/11- Regular Seal

1900-1919

U. S. Navy, Ret.

U. S. Navy, Ret.

Unknown

Unknown

Yes, WW I & WW II 1918-1919 1941-1945
James Jacksonville 1900-1919 1941-1945
Sweet Air Road Jacksonville, Fla

1918-1919

Buried 1-23-1962 Arlington National

Buried 1-23-1962 Arlington National

Brooks Funeral Service, Inc. Towson Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many events, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00382											
00380											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville						c. LENGTH OF STAY IN lb 5yr10mth17dys					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hollywood, Maryland					
3. NAME OF DECEASED (Type or print) First Pirley Middle C Last Weeks						d. STREET ADDRESS none					
4. DATE OF DEATH Month January Day 15 Year 19 62						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1876		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 15 Days 19 Hours 62 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY shipyard				11. BIRTHPLACE (County & State, or foreign country) New York			
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Willet Weeks				14. MOTHER'S MAIDEN NAME Sadie New			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none				16. SOCIAL SECURITY NO. unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia											
DUE TO (b) Arteriosclerotic cardiovascular disease											
DUE TO (c) Arteriosclerotic cardiovascular disease											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 28, 1956 to Jan. 15, 1962 that (I) (we) last saw the deceased alive on Jan. 15, 1962 and that death occurred at 1:20 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachsler						22b. DATE SIGNED 1-15-62					
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-18-62		23c. NAME OF CEMETERY OR CREMATORY Gry Chapel				23d. LOCATION (City, town or county) (State) Leonardtown, Md	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley						25a. REC'D BY REGISTRAR DATE JAN 19 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

2950

2.

٢٠٠٠

CERTIFICATE OF DEATH

Reg. Dist. No. 00381

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5705 McCormick Ave.				d. STREET ADDRESS 5705 McCormick Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Susanna Middle Wendling Last Wendling				4. DATE OF DEATH Month Jan. Day 10, Year 19 62			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1883		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? Hungary	
13. FATHER'S NAME John Yost				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Margaret Moose Address 5714 McCormick Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Descending Colon 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized abdominal distention							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. 79		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 19 61 , to Jan 10 19 62 , that I last saw the deceased alive on January 8 19 62 , and that death occurred at 12:49 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1337 S. Charles St DATE SIGNED ACTUAL SIGNATURE John A. Scheurich M.D. PHYSICIAN'S NAME (Type) John A. Scheurich M.D. Balto 30. Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/62		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens ADDRESS 1501 E. Fort Ave.				24a. REC'D BY REGISTRAR DATE JAN 15 '62		24b. REGISTRAR'S SIGNATURE Clinton B. Kiser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Handwritten: John A. Smith]</p>		<p>2. SEX [Handwritten: Male]</p>	
<p>3. AGE [Handwritten: 45 years]</p>		<p>4. DATE OF BIRTH [Handwritten: Jan 15, 1880]</p>	
<p>5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>		<p>6. OCCUPATION [Handwritten: Clerk]</p>	
<p>7. MARITAL STATUS [Handwritten: Married]</p>		<p>8. DATE OF MARRIAGE [Handwritten: Nov 10, 1905]</p>	
<p>9. NAME OF SPOUSE [Handwritten: Mary E. Smith]</p>		<p>10. DATE OF DEATH [Handwritten: Dec 10, 1925]</p>	
<p>11. PLACE OF DEATH [Handwritten: Home]</p>		<p>12. CAUSE OF DEATH [Handwritten: Heart Disease]</p>	
<p>13. MEDICAL HISTORY [Handwritten: Hypertension, Diabetes]</p>		<p>14. PRESENT ILLNESS [Handwritten: Angina pectoris]</p>	
<p>15. PHYSICIAN'S SIGNATURE [Handwritten: J. H. Jones, M.D.]</p>		<p>16. COUNTY CLERK'S SIGNATURE [Handwritten: W. H. Brown]</p>	
<p>17. COUNTY CLERK'S NAME [Handwritten: W. H. Brown]</p>		<p>18. COUNTY CLERK'S TITLE [Handwritten: Clerk]</p>	
<p>19. COUNTY CLERK'S ADDRESS [Handwritten: 123 Main St., Baltimore, Md.]</p>		<p>20. COUNTY CLERK'S PHONE NUMBER [Handwritten: 1234]</p>	

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00384 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00382											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grey Manor c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2900 Page Drive						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grey Manor d. STREET ADDRESS 2900 Page Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GENEVA ETHEL WHEATLEY						4. DATE OF DEATH January 10, 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1918		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Virginia		
13. FATHER'S NAME Chester Adkins						14. MOTHER'S MAIDEN NAME Don't know					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT John Wheatley Address 2900 Page Drive-22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insuff DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 10 min 8 yrs	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Jack C. Collins M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Jack C. Collins DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1-11-62											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/62		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or country) (State) Baltimore, Md.					
23. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Dundalk, Md.						24a. REC'D BY REGISTRAR 15 '62		24b. REGISTRAR'S SIGNATURE C. Stuart E. Harris			

104 STATE
HALL BOSTON



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18, Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

3
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00385. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00383

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 14 Mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8045 Park Haven Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 8045 Park Haven Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HOLLY ELIZABETH WHITTLE				4. DATE OF DEATH January 31 19 62			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 29, 1960	
9. AGE (In years last birthday) 1 1/4 mos.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gorman E. Whittle				14. MOTHER'S MAIDEN NAME Carol Bond			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gorman E. Whittle - 8045 Park Haven			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis and pulmonary atelectasis DUE TO (b) S2S Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. Breitenecker, M.D.		EXAMINER'S NAME (Type) R. Breitenecker, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 31, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-62		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or country) (State) Trumps Mill Rd., Md.	
23. FUNERAL DIRECTOR ADDRESS				24a. REC'D BY REGISTRAR JOHN J. DDDA		24b. REGISTRAR'S SIGNATURE 7922 Wise Av.,	

FEB 5 '62

Arthur S. Hays Dundalk 22 Md.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00386

00384

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2824 Frederick Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>2824 Frederick Rd</u>									
3. NAME OF DECEASED (Type or print) <u>CURTIS F. Wilcox</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>27</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 6, 1876</u>		9. AGE (In years last birthday) <u>85</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>									
13. FATHER'S NAME <u>Charles S. Wilcox</u>			14. MOTHER'S MAIDEN NAME <u>Reese</u>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Irene Gilgash 2824 Frederick Rd</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="vertical-align: top;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> </td> <td colspan="2" style="vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> </td> </tr> <tr> <td colspan="2" style="vertical-align: top;"> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) </td> <td colspan="2" style="vertical-align: top;"> </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>		CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>											
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Secondary Pneumonia</u>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="vertical-align: top;"> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> </td> <td style="vertical-align: top;"> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </td> <td style="vertical-align: top;"> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) </td> <td style="vertical-align: top;"> 20f. (City or town) </td> <td style="vertical-align: top;"> (County) </td> <td style="vertical-align: top;"> (State) </td> </tr> </table>						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)								
21. I certify that (I) (this hospital) attended the deceased from <u>1-6-62</u> to <u>1-27-62</u>, that (I) (we) last saw the deceased alive on <u>1-26-62</u> and that death occurred at <u>2:00</u> M., from the causes and on the date stated above.													
22a. SIGNATURE <u>James Stowarz</u> M.D.				22b. DATE SIGNED <u>1-29-</u>									
22c. PHYSICIAN'S NAME (Type) <u>Catonville</u>				22d. ADDRESS <u>1-29-</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 30, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW Cem.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>E.B. Malt Nabb + Son</u>		24b. ADDRESS <u>(23)</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 '62</u>									
25b. REGISTRAR'S SIGNATURE <u>Clifford L. Heenan</u>													

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 1 of 2 retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Page 2 of 2 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

38800



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00387

CERTIFICATE OF DEATH

00385

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>111 Burke Avenue</u>				d. STREET ADDRESS <u>111 Burke Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Sara A. Wilson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Belfast, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William McMeekin</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mr. Mathew Wilson-111 Burke Avenue- Towson</u>			
17. INFORMANT <u>Mr. Mathew Wilson-111 Burke Avenue- Towson</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>None</u> 19 p.m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 19</u> to <u>Jan. 30</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Jan. 19</u> , 19 <u>62</u> , and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>I. Carl Myers</u>				22b. DATE SIGNED <u>Jan. 31, 62</u>		22c. PHYSICIAN'S NAME (Type) <u>J. Carl Myers, M. D.</u>	
22d. ADDRESS <u>1401 E. Cold Spring Lane Balto., 12, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Suckner & Sons</u>				25a. REC'D BY REGISTRAR <u>Baltimore 17, Maryland</u>			
25b. REGISTRAR'S SIGNATURE <u>Feb 1 '62</u>				25c. DATE <u>FEB 1 '62</u>			

00880

00880



00388

CERTIFICATE OF DEATH

Reg. Dist. No. 00386

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Professional House		d. STREET ADDRESS 3005 Virginia Avenue	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle WINAKUR Last WINAKUR		4. DATE OF DEATH Month January Day 25 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1885
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Frank Meyer		14. MOTHER'S MAIDEN NAME Mary ? Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4433X IMMEDIATE CAUSE (a) Virus Pneumonia DUE TO (b) Hypertensive Cardio Vascular Disease DUE TO (c) Cerebral Thrombosis - with deep Hemiplegia		INTERVAL BETWEEN ONSET AND DEATH About 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphatic Leucemia - Discovered 11/23/59		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/13/59 , 19 59 , to 1/25/62 , that I last saw the deceased alive on 1/24/62 , 19 62 , and that death occurred at 5:28 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Theodore H. Morrison M.D.		ADDRESS (Street, city or town, state) 11 E. Chase St. DATE SIGNED	
PHYSICIAN'S NAME (Type) Theodoro H. Morrison		11 E. Chase Street	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 26/62	22c. NAME OF CEMETERY OR CREMATORY Shomra Shabos	22d. LOCATION (City, town, or county) (State) German Hill Rd Balto., Md
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros Inc ADDRESS 6010 Reist Road		24a. REC'D BY REGISTRAR JAN 29 '62	24b. REGISTRAR'S SIGNATURE J. H. H. H.

TO HOSPITAL OR ALTERNATE CARE: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1932

CERTIFICATE OF DEATH

No. 101

DATE OF DEATH

January 10

1932

AGE

61 years

Place of Birth

3005 Virginia Avenue

City

Married

Wife

January 25

Place of Death

1000 10th St.

City

Residence

1000 10th St.

City

Frank Meyer

1000 10th St.

to

1000 10th St.

THE STATE OF TEXAS, County of Dallas, ss. I, the undersigned, a Notary Public in and for said State, do hereby certify that the foregoing is a true and correct copy of the original of the Certificate of Death of the person named therein, as the same appears from the records of the State of Texas, in and for said County, at this day of January, 1932.

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00389

01682

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONVILLE				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 501 ACADEMY RD				d. STREET ADDRESS 1501 ACADEMY RD.			
3. NAME OF DECEASED (Type or print) CHRISTIAN H. WOLFE				4. DATE OF DEATH Month JAN. Day 30 Year 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11 1901		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN TRANSIT CO				10b. KIND OF BUSINESS OR INDUSTRY MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY WOLFE				14. MOTHER'S MAIDEN NAME KATIE BLANK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give year or dates of service)				16. SOCIAL SECURITY NO. —			
17. INFORMANT Mrs. C. H. Wolfe - 501 Academy Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO Acute Coronary artery occlusion & Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Coronary artery sclerosis (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 14 , 19 55 , to Jan 30 , 19 62 , that (I) (we) last saw the deceased alive on Jan 30 , 19 62 , and that death occurred at 6:30 P. from the causes and on the date stated above.							
22a. SIGNATURE Harry L. Knipp, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-31-62	
22c. PHYSICIAN'S NAME (Type) HARRY L. KNIPP, M.D.				22d. ADDRESS 4116 Edmondson Ave. Baltimore 29, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-2-62		23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEM		23d. LOCATION (City, town or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Forley Carroughs Funeral Home Catonsville				ADDRESS		25a. REC'D BY REGISTRAR FEB 8 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

01002

00000



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13

00390

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14

M

1

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X 1902 Augusta Avenue * Dundalk, Md.</u>	
c. LENGTH OF STAY IN 1b <u>4yr8mth27dys</u>		d. STREET ADDRESS <u>1 1902 Augusta Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stanley (Stanislaw) Wolosz</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30, 1893</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>insurance</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wolosz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Liptvics</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-10-8306</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>493X</u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic heart disease - hypertensive</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that He (this hospital) attended the deceased from <u>April 5, 1957</u> , to <u>Jan. 2, 1962</u> , that he (we) last saw the deceased alive on <u>Jan. 2, 1962</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Bruno Radauskas</u> M.D.		22b. DATE SIGNED <u>1-2-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSP. Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-5-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary</u>		23d. LOCATION (City, town or county) (State) <u>German Hill Rd. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA</u>		25a. REC'D BY REGISTRAR <u>7922 Wise Ave. 22, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>JAN 8 '62</u>	

00000

00000

M

20

1985

James L. [Signature]

JOHN F. DUFF, JR., 1985 WINE AVE., 25. 20.

JOHN F. DUFF, JR., 1985 WINE AVE., 25. 20.

CERTIFICATE OF DEATH

Reg. Dist. No. 00388

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davis Ave. Granite Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Granite Hills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Otto Yeager - Yeager</u>				4. DATE OF DEATH <u>Jan 1 - 1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 11 - 1898</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. P.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John Yeager</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Ernest A. Hipsley - Davis Ave Granite Hills</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure, arteriosclerotic heart</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction, Hypertension,</u> DUE TO <u>rt hemiplegia</u> (c) <u>rt hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>70</u> <u>1962</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1960</u> , 19, to <u>1962</u> , 19, that I last saw the deceased alive on <u>1 Jan 62</u> , 19, and that death occurred at <u>8:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Granite Hills, Md.</u> DATE SIGNED <u>2 Jan 62</u>			
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan 4 - 62</u>			
22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem</u>			
22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller</u> ADDRESS <u>2431 E. Olney St</u>			
24a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00392											
00389											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Towson						c. LENGTH OF STAY IN 1b X Rural Towson					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Villa Maria - Notch Cliff						d. STREET ADDRESS Glenarm, Maryland					
3. NAME OF DECEASED (Type or print) Sister M. Hubertina (Zinkand)						4. DATE OF DEATH January 17 19 62					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1874		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS				11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY United States	
13. FATHER'S NAME Peter Zinkand						14. MOTHER'S MAIDEN NAME Helen Bittrof					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Sr. M. Henrica		Address Villa Maria Glenarm, Maryla			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 33X IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 da. 8 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Towson		(County) Towson		(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from February 10, 1962 to January 10, 1962 , that (I) (we) last saw the deceased alive on January 10, 1962 , and that death occurred at 11:20 a.m. from the causes and on the date stated above.											
22a. SIGNATURE Dr. Charles F. O'Donnell						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell						22d. ADDRESS 7501 York Road Towson - Towson 4, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-20-62		23c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		23d. LOCATION (City, town or county) (State) NOTCH CLIFF NR TOWSON, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Jelen						ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		25a. REC'D BY REGISTRAR JAN 22 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kane	

00392



Alfred B. Campbell

Charles J. Felt
4012 Conkling St.
Baltimore, Md.

1-30-63, VERA MARIA CATH. MICHIGAN TOWNSHIP, MD.